THE ABA AUTHORIZATION AND APPEALS PLAYBOOK

16TH ANNUAL

AUTISM LAW SUMMIT

OCTOBER 2022

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INTRODUCTION

FOR OVER TEN YEARS, the autism community successfully worked together to enact autism insurance reform across the country. What an accomplishment! While some form of meaningful insurance coverage for autism/Applied Behavior Analysis (ABA) is required in all fifty states, individuals with autism spectrum disorder (ASD) and their providers still face challenges when trying to access medically necessary care. Two main barriers remain: plan limitations and medical necessity denials.

- Plan limitations are explicitly written into the plan documents most often as a full exclusion ("ABA is not a covered benefit"), a cap (age, dollar, or visit limits), or a specific treatment limitation (e.g., treatment is excluded in a school setting).
- Medical necessity denials are based on the judgment of a reviewer employed by the insurer who determines whether all of the recommended treatment is clinically appropriate. The denial may be for all of the request or for elements of it such as dosage, location, timeframe, etc. Denials most often happen as part of the utilization management (UM, a.k.a., authorization) process. When services for a patient are denied or partially denied because they are deemed not medically necessary, the individual and their provider can file internal and external appeals and leverage other legal protections afforded them through federal and state laws.

This guide was written by experienced providers, regulators, and advocates to help individuals and providers who are experiencing medical necessity denials. While we do not focus as explicitly in the guide on plan limitations, the general approach can be applied to them. As a group, we were able to share experience, knowledge, tips and insights, to identify the information and strategies that would be most useful to providers in securing authorization for medically necessary services and appealing denials. We recommend that interested parties read the Health Insurance Appeals Guide published by the Council of Autism Service Providers in conjunction with this Guide.

The authors' biggest take-away from this effort is that to best serve their clients and protect the integrity of the field of ABA, providers need to be better educated about the laws that protect health care consumers, and the role of the regulators who enforce those laws. We set out to do that, and it was a team effort! In this guide, we attempt to explain how all the pieces fit together, and how providers can use the law to better advocate for their clinical recommendations and patients. The ultimate goal of this guide is to empower the community to effect long-term systematic changes that will make it easier for families to access the care they deserve.

This document primarily discusses ABA coverage offered through commercial health plans and the applicable rules and rights available to members. While the guide references government-backed plans such as Medicaid or Tricare at points, the information provided is most relevant to commercial plans.

HOW TO USE THIS GUIDE

This guide is broken down into three key sections. For all users of this guide, we first recommend reading it from start to finish, and then after that, using it as a reference guide and "playbook" when submitting appeals and complaints.

CHECKLIST FOR ADVERSE DETERMINATIONS AND MEDICAL NECESSITY APPEALS

This four-page checklist provides a summary and roadmap to the appeals process. The rationale for each step is explained throughout the guide. Hyperlinks connect to the relevant section.

PART I: THE BASICS

This section lays out the key concepts, terms, and laws that all insurance-funded providers must know. It also explains the role of insurance regulators in enforcing the laws that protect insurance consumers.

PART II: THE PLAYBOOK

This section is the "how-to" guide for effectively seeking authorization, appealing denials, and soliciting help from third parties such as regulators, advocates, and lawyers. At each step of the process, Part II provides helpful insights on specific legal protection that apply and how a provider or member can access them. This guide does not offer details on how to construct a clinical defense of a recommended treatment but instead focuses on the legal and procedural framework that protects providers and patients who are seeking appropriate and medically necessary treatment.

PART III: TIPS AND TOOLS

This section provides checklists, timelines, and sample letters. It also explores challenges faced by those seeking ABA treatment and the three of the most Common Issues. Each is explained and sample language provided that can be used in appeal letters and complaints to regulators.

KEY TERMS

For many of the concepts discussed in this guide, multiple terms could be used. For example, a person receiving treatment may be referred to as a patient, client, or individual with autism spectrum disorder. For the sake of clarity and consistency, this guide uses the naming conventions listed below. Also, as mentioned above, readers are encouraged to use the Appendix B: Glossary *as well as the Key Acronyms and Glossary section of the* CASP Health Insurance Appeals Guide *for additional definitions.*

Applied Behavioral Analysis (ABA) – The scientific study of behavior change, using the principles of behavior, to evoke or elicit targeted behavioral change through a properly licensed professional.

Consumer – A person who has purchased a commercial health insurance policy.

Insurer – The company that administers a health plan. The entity with which the patient/provider interacts when seeking authorizations or payments, submitting denials and appeals, etc. Regardless of who holds the underlying financial risk of a health plan (see the section about plan types), most patients think of the plan administrator as "the insurance company." We use the term "insurer" in this guide.

Member – A person who is enrolled in a health plan. This can be used to refer to both the primary insured individual (a.k.a. the subscriber or enrollee) and also their dependents.

Patient – The individual receiving the services. Since many patients receiving ABA are minors, "patient" may also refer to the parent/guardian acting on the patient's behalf (e.g., "The patient should be notified.").

Plan or Health Plan – The insurance contract that outlines the specific terms and benefits available to a member. Insurers offer many different plans, each with its conditions.

Provider – The ABA provider who is treating an individual with autism.

CHECKLIST FOR ADVERSE DETERMINATIONS AND MEDICAL NECESSITY APPEALS

The authors of this playbook did their best to compile all information into one place, simplify and explain concepts, and provide useful tools. That being said, it contains a lot of information! To help provide a framework for all information in this guide, we created a step-by-step checklist to use when appealing an adverse determination based on medical necessity. It incorporates the "rules" that the insurers must follow to provide each member with the full and fair review that they are entitled to as consumers of a product in a government-regulated market. ***All steps should be tracked and documented!*** Each step is more thoroughly explained in the guide itself, and where appropriate, we point you to key sections of the guide that should be referenced.

WE HIGHLIGHT TWO TYPES OF POTENTIAL ISSUES THAT MAY WARRANT COMPLAINTS TO A REGULATOR:

- Anything marked with "**" is a basic process or timeline violation. If you experience those, we recommend you see the Common Problems section titled The Insurer is Violating Utilization Management Protections.
- Potential substantive concerns about the guidelines or the judgment being applied are highlighted. In those cases, we point you to the Common Problems section of this guide which may be useful.

STEP #1: GET PREPARED AND EDUCATED

- If you haven't already done so, start documenting and tracking every step!
- Get the adverse determination in writing.
    - Was it difficult to get the insurer to send the decision in writing?*
    - Were you notified of the decision within 15 days of the authorization request?*
- Notify the patient/caregiver of the adverse determination and your clinical recommendation that an appeal is in the best interest of the patient.
    - Ensure the patient understands the clinical rationale and is supportive of the effort.

- Ask patient/family for a copy of the SPD and review it.
    - Determine the plan type (fully-insured or self-funded, group or individual), the regulator, and the key contractual terms of the plan.
- Based on the type of plan, determine whether federal or state laws apply. The key utilization management protections for federal laws (such as the timelines) are outlined in this guide. For state-regulated plans, visit www.regquest.com to understand the consumer protections available in each state. (You will need to create an account, but it is free.) If both federal and state laws apply, determine which are the most protective.
    - For state-regulated plan, review the particular state's autism insurance laws and associated regulations to understand what benefits the plan is required to provide. Keep this mind: It is common to find out that many of the exclusions or limitations in state insurance laws related to autism are not being enforced (because it has been determined that they are discriminatory) so don't be discouraged if you see age, hours, or dollar caps in the state law. They may be obsolete. (See the section titled State Specific Autism Regulations for more information on how to determine this.)
- Determine the appeal process of the plan by reviewing the adverse determination letter and the SPD. Questions to consider:
    - How many levels of appeal are allowed/required? How much time does the insurer have to respond at each level? Where should the appeal be sent?
        - Do the insurer's stated response timelines meet the standards established by state and federal law?**
    - Determine if any specific forms are required to be submitted and who needs to submit them, such as a Member Appeal Form and/or an Authorized Representative Form.
        - Collect the forms from the member as needed.

STEP #2: UNDERSTAND THE DECISION THAT WAS MADE

- Gather all information available about why the adverse determination decision was made.
    - Review the denial reasons as stated in the adverse determination letter.

- Pursue any options offered in the adverse determination letter to understand the decision better, such as phone calls or document requests.
- Contact member/provider services and/or the utilization management department to request:
  - The medical necessity criteria that were used to make the decision.
  - Any clinical guidelines, policies, criteria, or scientific literature that were applied in making the decision and how they were ***specifically applied to the member.***
    - If you are pointed toward any large policy documents, ask for the specific page numbers that are related to the adverse determination.
- Have the member complete and submit the insurer's "Authorization for Release of Protected Health Information" form and ask the insurer to release their full case file (i.e., all records) to the provider.
- Was the information you requested sent to you, and if so, was it sent within a reasonable timeframe? **

- Review the information provided in the adverse determination letter and/or in the additional information that you gathered to understand the decision.
  - Does the decision clearly explain the scientific justification for why the decision was made and how the decision was specific to the patient or does it say something vague such as "This is not medically necessary" without providing a rationale?
    - If the "Why" is not clear, see the Common Problem: Insufficient Explanation section for guidance about language to include in the appeal.
  - For fully-insured plans, does the decision abide by all state-specific autism laws?
    - If not, be prepared to cite the law in the appeal.
  - Do the medical necessity guidelines that were applied by the insurer align with the generally accepted standards of care in the industry?
    - If not, see the Common Problems section titled Medical Necessity Criteria Do Not Align with Generally Accepted Standards of Care for guidance about language to include in the appeal.
  - Was the decision predictable, or do you get a different (often inexplicable) answer from that insurer every time you request an authorization?
    - Authorization decisions must be made per the plan's provisions

and, where appropriate, must be applied ***consistently*** for similarly situated claimants.
    - Unpredictable decisions may be grounds for a regulator complaint.

STEP #3: COMPILE AND SUBMIT AN APPEAL WITHIN THE PLAN'S TIME LIMIT

- Compile an appeal packet (see the section titled Elements of an Appeal Packet).
    - Most ABA appeal submissions should include a MHPAEA disclosure request. See section titled Submitting a MHPAEA Disclosure Request and Reporting Non-Compliance.
- Send packet and track it.
- Call the insurer within a few days to confirm receipt.

STEP #4: RECEIVE AND REVIEW THE APPEAL RESPONSE

- If the response is not received by the deadline, contact the insurer to ask about the status.
- If the response was favorable, congratulations! Contact the insurance company to request an updated authorization for services.
- If the response was NOT favorable, continue to the next level of appeal.
- Were you notified of the response within the required timeframe?**
    - If not, and a second level of appeal is required, choose whether to continue the internal process or skip to an external review per the deemed exhaustion clause. For external review, skip to Step #6.
- Do you see a pattern of receiving adverse determinations that are overturned upon appeal (i.e., you have to jump through extra hoops each time to have services authorized)?
    - Any problematic pattern should be tracked and reported to the regulator.
- If this was the final level of appeal, was an external review offered?** (Note: an external appeal is a guaranteed right for ***members*** for medical necessity determinations under the Affordable Care Act (ACA).
- If a MHPAEA disclosure letter (as described below) was submitted, did the insurer respond within 30 days?
    - Insurers must respond to a MHPAEA disclosure request within 30 days. If they do not, report the violation to the regulator and The Kennedy Forum. See the section titled Submitting a MHPAEA Disclosure Request and Reporting Non-Compliance for guidance.

STEP #5: IF A SECOND LEVEL OF INTERNAL APPEAL IS REQUIRED, RETURN TO STEP #2 AND REPEAT

- You will likely be offered access to policies and notes related to the first decision. Even if you called before the first appeal to request relevant documents and criteria, do so again to see if you can gain access to any additional internal documents related to the most recent decision.

STEP #6: FOR A MEDICAL NECESSITY DENAIL, ONCE ALL INTERNAL LEVELS OF APPEAL HAVE BEEN EXHAUSTED, THE MEMBER CAN REQUEST AN EXTERNAL APPEAL AND SUBMIT ALL DOCUMENTS

- Was an external review allowed (either due to exhaustion of all internal levels or deemed exhaustion) when it should have been?**
- Did you receive a response from the plan about the request for an external review within 6 days of the request?**
- Did the IRO respond within 45 days?**
- Note: some experts recommend consulting a lawyer before going to an external review. If the adverse decision is upheld by an "independent expert," it may be harder to make a case in court if you intend to pursue that route.

AT ANY TIME: SUBMIT A COMPLAINT TO THE REGULATOR

- If you believe that the plan has violated the law, you should notify a regulator so that the plan can be held accountable. You can submit a regulator complaint at any point in this checklist, but we recommend submitting one after the insurer responds to the first-level appeal. That way, you can show that you made a good faith effort to resolve the issue directly with the insurer.
- If an insurer is repeatedly committing the same violation (i.e., a pattern), consider submitting a complaint to the regulator for each patient as soon as the violation is committed. While the complaint must be tied to one patient, reference the pattern being observed.
- See the section titled Regulator Complaints.

PART I: THE BASICS

THIS SECTION EXPLAINS the key terms and principles every provider must understand to effectively work with insurance plans and support their patients. These concepts lay the foundation for the rest of the guide.

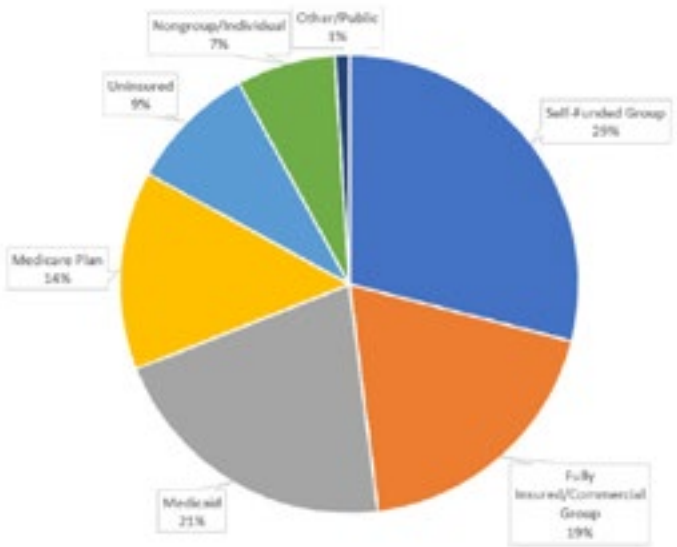
INSURANCE IS A REGULATED INDUSTRY

Insurance coverage products are regulated to protect consumers. Health insurers are governed by federal and state laws that identify key practices – practices they are required to adhere to and practices that are prohibited. Government regulatory agencies monitor and audit the insurance companies to ensure they are abiding by those laws, and support consumers whose rights are being violated. The type of coverage a person has will dictate which regulator is in charge.

TYPES OF HEALTHCARE COVERAGE

While all healthcare insurance offerings generally do the same thing (i.e., pool risk), key differences exist that are important to understand. The main differences are usually based on how the individual got the coverage (through an employer, an insurance marketplace, etc.) and who assumes the underlying financial risk of paying for claims. These differences dictate which federal and/or state laws apply to the coverage and which regulatory agency has primary authority to oversee the insurer and its plans. Providers must understand the type of plan that each patient has to properly navigate issues that may arise. The pie chart shown demonstrates the percentage of the U.S. population who are enrolled in different types of plans.

US Population Percentage by Health Insurance Type



This pie graph is based on several sources of information, including 2019 data from the Kaiser Family Foundation.

COMMERCIAL PLANS

EMPLOYER-SPONSORED PLANS

Many companies offer health insurance to their employees as a benefit of employment. Often, this employee benefit will include the company paying part, or all, of the insurance premiums for the employee. All employer-sponsored plans are regulated by a federal law named the Employee Retirement Income and Security Act of 1974 (ERISA). ERISA offers broad consumer protections and sets disclosure requirements. It is referenced often in this guide and explained in more detail below.

There are two main types of employer-sponsored plans, fully-insured plans and self-funded plans. While there are important differences between the two types, it is usually not possible to determine the type of plan simply by looking at the member ID card. Most patients will not know which type of insurance they have.

HOW TO DETERMINE IF AN EMPLOYER-SPONSORED INSURANCE PLAN IS FULLY-INSURED OR SELF-FUNDED

TIP #1: Ask the representative during the benefits check process

- If a plan is fully-insured, then a provider should follow up with two additional questions: "In which state is the contract based?" and "Is it a large or small group plan?" The state laws (including state autism insurance mandates) that apply to the plan will be based on the state of the contrac, not on the state where the patient lives or services are delivered.
- Representatives may also refer to a self-funded plan as "Administrative Services Only" (ASO)

TIP #2: If the member ID card references a company "administering benefits" or similar language, coverage is likely self-funded, but confirm this in Tip #1.

TIP #3: Request a copy of the SPD and review it.

Fully-Insured Employer-Sponsored Plans

For fully-insured plans, the insurance company holds the underlying risk of funding the health care plan and paying all related claims. The insurance company is responsible for compliance with applicable laws. Employers pay premiums to an insurance company (e.g., Aetna, Cigna, Blue Cross/Blue Shield, etc.), which then

administers the plans and pays for claims from the money collected in premiums.

A fully-insured plan is based in a state, often the state where the employer's corporate headquarters is located, and the contract is governed by both the federal laws that apply to all employer-sponsored plans and also the laws of the state where the contract was written.

Fully-insured employer plans may be either large group plans (typically for companies with more than 50 employees) or small group plans (typically for companies with less than 50 employees). State laws are sometimes applied differently to fully-insured employer plans depending on whether they are large or small groups.

State-level general insurance laws and regulations apply to all fully-insured employer plans in that state. Autism-specific state laws will specify which plans (large group and/or small group) must cover treatments for autism.

The primary regulator of fully-insured plans is the relevant state's insurance department. This may be different than the state where the member resides.

Self-Funded Employer-Sponsored Plans

In a self-funded arrangement, an employer offers the health plan to its employees and assumes the underlying risk of funding the health care plan and paying all related claims. The employer is called the "plan sponsor" and is ultimately responsible for the plan's compliance with applicable laws. The money used to pay claims and administer the plan comes from an account owned and operated by the employer. The premiums paid are contributed to a collective pool, which is earmarked solely for the health needs of the employees and their dependents. Self-funded plans provide the employer more discretion on the policy and benefit design than is available through fully-insured plans (e.g., the employer can decide whether ABA is a covered benefit or not).

Most self-funded employer plans contract with a Third-Party Administrator (TPA) who operates and administers the plans. Third-Party Administrators are also referred to as "plan administrators" or "administrative services organizations" (ASOs). Many major medical insurers (e.g., Aetna, United Healthcare) also operate as TPAs, so consumers may see a familiar insurance company logo on their insurance ID cards. While the TPA is acting on behalf of the employer, the employer holds the "fiduciary responsibility" of operating the plan, so the employer will primarily be held responsible by the applicable federal regulatory agency if federal law is violat-

ed. In some cases, the TPA may also be held accountable by the applicable federal regulatory agency for violating federal law.

A self-funded plan is regulated by the federal laws that apply to all employer-sponsored plans, not by state laws.

State-level autism-related laws and regulations DO NOT apply to these plans. Employers can choose to cover ABA although such an exclusion exposes the employer to significant legal risk (see pop-out box below). If you encounter a plan with an ABA exclusion, consider informing the member that they may want to seek legal advice on how to proceed.

The primary regulator of self-funded plans is the Employment Benefits Security Administration (EBSA) of the U.S. Department of Labor (DOL).

DO SELF-FUNDED PLANS HAVE TO COVER ABA?

Thankfully, blanket ABA exclusions in employer-sponsored self-funded health plans are on the decline. For years, such an exclusion was based on a claim that ABA was experimental and that employers had the right to exclude experimental treatments. But as the body of efficacy evidence has grown, courts have ruled that ABA is not experimental and that its exclusion as experimental is impermissible.

That doesn't mean ABA exclusions in self-funded plans have become obsolete, unfortunately. In 2021, such an exclusion was litigated in federal court. Doe v. United Health Care is an ERISA challenge of United's refusal to cover ABA through its administration of an employee health plan. The family of a child with autism, who initiated the litigation, asserted that the exclusion violated MHPAEA. The judge agreed: "[T]he exclusion carves out and rejects from coverage a core treatment for Autism: ABA therapy. As [Plaintiff] correctly highlights, there are no comparable Med/Surg exclusions in the [United-administered] Plan. Thus, the exclusion, which excludes coverage for the primary treatment modality for a mental health condition, violates the plain language of the statute."

While it is becoming widely understood that MHPAEA protects against an ABA exclusion for the treatment of autism, MHPAEA does not appear to protect employers from sponsoring self-funded plans that do not cover autism at all. There are likely other federal laws that could challenge such a coverage decision (specifically the anti-discrimination provisions of the ACA) but as of the publication of this guide, there is currently no such case law that is specifically on point.

THE BOTTOM LINE IS THIS: if an employer chooses to cover autism in its self-funded plan, MHPAEA requires that any limitation on treatment for behavioral health conditions must be applied on par with medical conditions. If you encounter a plan with an ABA exclusion, consider informing the member that they may want to seek legal advice on how to proceed.

INDIVIDUAL PLANS

An individual plan (non-group coverage) is purchased directly from an insurance carrier or through a Health Exchange (e.g., Healthcare.gov). Consumers may use an insurance broker, assister, or navigator to help them select the plan that is best for them. Both federal and state laws apply to individual plans and understanding whether ABA is a covered benefit requires that the following questions are answered:

- Is the plan considered grandfathered or non-grandfathered?
    - **Grandfathered plans** are health plans that were in existence before the passage of the ACA (March 23, 2010) and have continued as they were originally written. These plans are not required to comply with some of the requirements of the ACA including the requirement for an external review.
    - **Non-grandfathered plans** are health plans that must comply with all relevant provisions of the ACA.
- Does the state's autism-specific insurance law require coverage in grandfathered and non-grandfathered individual plans?
    - Autism Speaks maintains information on state autism mandates and their applicability to grandfathered and non-grandfathered individual plans at www.autismspeaks.org/state-regulated-health-benefit-plans.
- If coverage is not required by the state's autism-specific law, but the plan is a non-grandfathered plan, is ABA covered as part of the state's package of Essential Health Benefits (EHB)?
    - States have some flexibility under the ACA to create an EHB package and they can also change or update their EHB package. For the states that have not included ABA in their EHB package, the current trend is for ABA to be added as a covered benefit.
    - Therefore, to know whether ABA is a required benefit for non-grandfathered individual plans in a particular state, research will often be required. One source for such information is a page maintained by Autism Speaks at https://www.autismspeaks.org/marketplace-health-insurance.

Additional information about individual plans: All individual plans are fully-insured, so the primary regulator is the relevant state's insurance department. Although individual plans are fully-insured, one cannot assume that the same state laws and regulations that apply to fully-insured employer plans apply to individual plans. States often have different regulations for fully-insured group plans and individual/non-group plans. For specifics on each state, visit www.regquest.com (you'll need to create an account, but it is free).

ALTERNATIVE INSURANCE

"Alternative insurance" products have very limited benefits and few consumer protections. When consumers are sold such products, they are usually sold short-term, limited-duration insurance or indemnity plans. In most cases, if a patient has this type of coverage, there will be limitations, exclusions, and maximum amounts that significantly limit reimbursement and coverage.

- The primary regulator depends on the coverage, but the state insurance department should be the first point of contact for concerns or complaints.
- State-level autism-related laws and regulations likely DO NOT apply to these plans.
- Many of the federal protections listed below, such as ERISA and MHPAEA, do not apply.

GOVERNMENT-BACKED PLANS

Government plans are health coverage options offered through a state or the federal government. In some cases, like Medicaid, the state administers the federal program. Some of the most common government plans are **Medicare**, **Medicaid**, and **TRICARE**. For the most part, this guide is not applicable to government-sponsored health plans, but some of the broader principles discussed in this publication do apply in terms of how to appeal a denial of care.

- **Medicaid** is a health care program that assists low-income families or individuals in paying for a variety of services, including outpatient visits, hospital stays, and long-term care. It is a program run by states, in partnership with the federal government. The primary administrator is the Centers for Medicare and Medicaid Services (CMS). Most managed care Medicaid organizations are regulated through the state insurance administrator or the state office Medicaid office.

Medicaid may also be available to persons with disabilities through a waiver program, where family income requirements are waived. In some states, children with autism may qualify for Medicaid benefits. This may be true even if the family has private coverage.

- **Medicare** provides health coverage to people aged 65 and older, or people under 65 who have a disability and have a work history or whose parents have a work history. Medicare is not income-based. Medicare plans are also overseen by CMS.
- **TRICARE**, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is a health care program of the U.S. Department of Defense Military Health System. The program is regulated by the Defense Health Agency in the Department of Defense.
- **Federal Employees Health Benefits (FEHB)** plans are offered to federal government employees and their dependents. FEHB plans generally offer multiple plan purchase options, sometimes referred to as basic and standard options. FEHB plans are governed by the U.S. Office of Personnel Management (OPM).
- **Non-Federal Governmental Plans** are state and county/local government employee plans. They can be fully-insured or self-funded. In many states, autism-related laws and regulations apply to state employee plans. See the section titled State Laws: State-Specific Autism Regulations for guidance about how to find information about state-level laws.
    - If self-funded, these plans are primarily regulated by the Department of Health and Human Services (DHHS), which can be contacted at Non-Fed@cms.hhs.gov.
    - If fully-insured, the plan is primarily regulated by the relevant state's department of insurance, but DHHS may also be able to help.

SUMMARY PLAN DESCRIPTION (SPD)/EVIDENCE OF COVERAGE

The scope of coverage and details associated with a health insurance plan is governed by a contract. For some types of insurance plans (i.e., fully-insured plans), it is a contract between an insurer and its members. For others (i.e., self-funded employer plans), it is a contract between an employer and its employees. Every plan has a document that includes the terms of the contract. The contract may go by different names, such as Summary Plan Description (for employer-sponsored

plans) or Evidence/Certificate of Coverage (for individual plans), but should answer the following questions:

- Who is covered?
- What are the cost-sharing arrangements? (e.g., deductibles, co-pays/co-insurance, out-of-pocket maximums)
- What are the covered benefits (i.e., what the plan will pay for)?
- What are the coverage exclusions or plan limitations (i.e., what the plan will not pay for)?
- What are the claims and appeal processes?
- What are the key terms in the policy?

KEY TERMS AND CONCEPTS

The following Key Terms and Concepts are found in all Summary Plan Descriptions (SPDs) and are relevant to advocating for clinically recommended care on behalf of patients.

COVERED HEALTH SERVICES

In the SPD, each plan defines what it covers (i.e., pays for). For example, some plans cover fertility treatments or bariatric surgery and some do not. Some plans cover ABA and some do not. Even when treatment is covered, there may be limitations such as the need for prior authorization, session limits, or visit limits. These coverage details should all be listed in the SPD.

The term "Covered Health Services" (a.k.a., Eligible Health Services) is typically defined as services, supplies, or pharmaceutical products that are:

- Described as a "Covered Benefit" in the benefits section of the SPD;
- Determined to be medically necessary per the applicable guidelines; and
- Not listed in the "Exclusions" section of the SPD.

For a health service to be a "Covered Benefit/Eligible Health Service," it must be both a covered benefit and medically necessary. For example, a plan may cover chemotherapy (listed as a "Covered Benefit") but it will not pay for it if the patient does not have cancer. In that case, the treatment would not be medically necessary.

MEDICAL NECESSITY/MEDICALLY NECESSARY

Medical necessity is one of the most important terms found in an SPD. This concept dictates what can and cannot be covered. If a covered benefit is determined to be medically necessary, then a health insurer is required to pay for it (unless it is listed as an exclusion).

While the definition of medical necessity may differ slightly, the general definition is:

Health care services that a professional, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose or treat an illness, injury, disease, or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice (see definition below);
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for a patient's illness, injury or disease (i.e., follow the research!);
- not primarily for the convenience of a patient or health care provider (e.g., a child cannot be at a center all day because the parent needs childcare if the child does not need that level of treatment);
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury, or disease. (Note: To date, no treatment has been proven to be as effective of a treatment for autism as ABA.)

GENERALLY ACCEPTED STANDARDS OF CARE

Generally accepted standards of care means the course of treatment that the average, prudent provider in a given community would prescribe under the same or similar circumstances. It aligns with:

- Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Recommendations from the healthcare provider specialty society (e.g., APBA, BACB, ABAI); and
- The views of other providers practicing in relevant clinical areas.

Generally accepted standards of medical care regarding ABA are more clearly developed and defined than they were even a few years ago. **When advocating for a patient's needs, providers must point to the established standards that support the treatment plan.**

There are several documents currently available that detail the generally accepted standards of care for ABA:

- Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (published by CASP);
- Clarifications Regarding Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers (published by the APBA and the BACB);
- The Model Coverage Policy (prepared by the ABA Coding Coalition).

AUTHORIZATION/UTILIZATION MANAGEMENT

Authorization is a process by which an insurer approves the request of a medical or mental health provider to deliver a service. Insurers also use the terms **Utilization Management (UM) or Utilization Review (UR)** process or mention the UM or UR department when referring to authorizations or the departments that issue them. An insurer may have an in-house UM department or may contract with a third-party agency to provide that service.

There are three main categories of authorization:

- **Prior authorization/pre-authorization/ pre-service claim** – a request to authorize services before they are delivered or at the beginning of treatment;
- **Concurrent review** – Authorizations for continued treatment while the treatment is being rendered or during a hospital stay; and
- **Retrospective review** – Authorization after the care has been rendered for purposes of reimbursement.

In the world of ABA, authorizations are almost always requested before services are delivered (via prior authorization or pre-authorization) or for successive treatment periods (via concurrent authorization). For the sake of simplicity in this guide, we mostly use the term prior authorization since that is usually how the treatment is listed in the SPD (e.g., "Benefits that require prior authorization").

Assuming ABA is a covered benefit in a plan, then the decision to grant or deny authorization for a recommended treatment plan is based on whether the plan administrators determine ABA is medically necessary under plan guidelines. Insurers use the authorization process as a way to contain costs for treatments they believe to be expensive or that may pose risks to patients. If prior authorization is required but not obtained before the delivery of services, the claims may be paid with a penalty, or a similar consequence, or denied altogether. The consequence should be listed in the SPD.

APPEALS/COMPLAINTS/GRIEVANCES (I.E. "WE DO NOT AGREE!")

There are times when a member or provider will not agree with an insurer's policies, procedures, or decisions. When that happens, there are ways to complain, and/or ask for a change in a decision or in the underlying policy that may have informed the decision. Each insurer has its process for processing complaints/grievances and appeals. Providers should always check the SPD for information about how to submit a complaint, grievance, or appeal. In-network providers should also check their provider manual. **Members and providers must follow the outlined processes to access the full set of protections they afford.**

These are the most common definitions used by plans:

- **Complaint or grievance** – A member or provider can file a complaint or grievance to express a disagreement with the terms of the SPD, the behavior of the insurer, or another administrative matter.
    - Sample reasons for complaints/grievances include **a coverage dispute** (i.e., ABA is not a covered benefit or not covered in specific situations, or the plan lacks an adequate provider network) or a procedural dispute (e.g., an insurer not providing a written denial for services, not responding to requests for information or submission of a claim).
- **Appeal –** A member or provider can file an appeal to ask for reconsideration of a decision that the insurance company has made. There are two main types:
    - **Clinical / Medical Necessity appeal** – This is used when a member or provider is contesting the insurer's determination that the proposed treatment, or even part of it, is "not medically-necessary" or is "experimental." This appeal is used when clinical judgment is involved and there is a discrepancy between the judgment of the clinical provider

and the insurance plan's reviewer. If a plan has an ABA benefit, but a reviewer did not approve all or some of the requested treatment plan because, in their judgment, it was not medically necessary, then a member can file a Clinical/Medical Necessity appeal. Most of this guide focuses on the process and protections for Clinical/Medical Necessity appeals.

- **Administrative appeal** – An administrative appeal would be used in situations that are not related to medical necessity (i.e., not based on the medical judgment of an insurance plan reviewer). Examples include a dispute about the terms of the plan contract, a claims issue, or the denial of out-of-network coverage when an adequate network of providers is not available.

An example: ABA is listed as a covered benefit that requires pre-authorization. A provider seeks authorization for treatment in a school setting, which is medically necessary based on the behaviors being targeted.

- If there are no specific exclusions in the plan that are relevant to the recommended treatment and the authorization request is denied as "not medically necessary," then the provider should submit an appeal of the decision and explain how the services are medically necessary.
- If "treatment in a school setting" is listed as an exclusion, the services will likely not be authorized even if the utilization management department agrees that the services are medically necessary. Note: if a provider encounters "treatment in a school setting" as an exclusion then the provider should submit a complaint to the insurer and the regulator because the exclusion could be considered a violation of MHPAEA.

AUTHORIZED REPRESENTATIVE

An **Authorized Representative** is a provider or other person that a member designates to act on his/her behalf. Insured plans are owned by the member, and the rights and protections discussed in this guide are for the member's benefit. Patients may choose to designate their provider as the authorized representative to have assistance in managing insurance or regulator processes on their behalf, particularly since the clinician is best suited to respond to questions about medical necessity.

To do so, most insurers and regulatory agencies have specific authorized represen-

tative designation forms that must be completed. Once a member completes it, the provider is then able to act on the member's behalf to submit complaints/appeals or ask the insurer directly for information. If a provider submits information on the member's behalf without including the form, it is possible the plan will not respond.

COORDINATION OF BENEFITS

A patient may have coverage from more than one health plan, for example, when a child is covered by the health care plans of two parents. If both plans cover a service, the primary plan will pay first, and the secondary plan will pay if there is a portion of the bill remaining.

Some families believe that they can choose to use whichever plan is better for coverage. That is NOT the case. The plan rules and the applicable regulations will decide which plan is primary and which plan is secondary. The coordination between two plans will differ on a case-by-case basis, but this list of general rules typically applies:

- If a patient is the member for one plan and the dependent for another plan, the plan in which he/she is the member will be primary. This may happen with the purchase of a child-only policy in which the child's policy will be primary, or when adults under age 26 get benefits through employment but are still on their parent's plan.
- In many states, if a patient is a dependent on multiple plans, COB is sometimes based on "the birthday rule" (i.e., which member's birthday is earlier in the year). If the mother has a birthday in March and the father has a birthday in November, then the mother's plan will be primary.
- If one plan is a COBRA or retirement plan and the other is an active plan, the active plan is primary.
- If one parent is custodial and there is no court decree stating which parent pays for health care, the custodial parent or their spouse's plan is primary, followed by the non-custodial parent/their spouse's plan.
- Government-based plans are always the payor of last resort (i.e., secondary). If a patient has a commercial policy plus Medicaid or Tricare, the commercial policy is always primary.
- Some plans claim they will not coordinate benefits with other plans, and that they are always primary. It is possible for both plans to claim to be primary. In this case,

the way the dispute is resolved will depend on applicable state law. If the dispute results in neither company accepting responsibility, the patient may need to file a complaint with one insurer and/or involve the appropriate regulator. This is not a very common situation.

WHAT SHOULD A PROVIDER DO IF A PATIENT HAS MORE THAN ONE PLAN?

A plan's SPD should have a section called "Coordination of Benefits" that outlines the specific rules and processes that govern how the plan interacts with other plans and what the member must do. Here is general guidance for steps a provider should take when there are multiple plans. Most importantly, the family MUST notify both the provider and the insurance companies of the existence of the other plan and must do so annually. If the plans are not notified but find out later, it can cause significant problems in reimbursement. As a provider, you must:

- Document that you have asked families if they have coverage from more than one plan in the intake paperwork, and again annually.
- Document in your paperwork annually that you have advised families of their obligation to notify both plans.
- Notify families that if the plans are not notified and there are COB issues, then they will be responsible for any resulting charges. A provider may want to develop paperwork that makes that responsibility clear and have patients sign it to indicate they understand that responsibility on intake and again on annual update documentation.
- Request pre-authorization from both the primary plan and the secondary plan.
- When submitting claims, indicate both health plans on the claim forms that are submitted. Always submit to the primary plan first, even if it does not cover the services. Then forward the response/Explanation of Benefits with the claim to the secondary plan.

REGULATORS

As mentioned above, health insurance is regulated at both the state and federal levels. Regulatory agencies monitor and audit the entities that offer health care coverage, such as insurance companies and plan administrators, to ensure they are abiding by the law.

While the term regulator may sound distant and bureaucratic, regulators are real people who work in the interest of the consumers. They want the insurers "to do the right thing," and they want to hold them accountable and require them to change their practices when they do not. In short, regulators can be an important and powerful ally for the autism community.

Regulators are often underutilized, however, due to a lack of understanding about who they are, and how and when they can help. While contacting a government agency may feel daunting, the regulators exist to help members and providers work with insurance companies, and in most states, regulators want to hear from members and providers who are experiencing difficulties.

For commercial insurance plans, there are two main regulators:

- For fully-insured plans (both individual and employer-sponsored group plans), the relevant state's department of insurance is the primary regulator.
- For self-funded plans, the U.S. Department of Labor is the primary regulator.

Within each regulatory agency, there is a **Consumer Services Department** to help members who are having a difficult time accessing services through their health insurance. Too often, ABA providers feel that they and their patients are being pushed around and treated unfairly by insurers, yet do not know where to turn for help. This is where regulators fit in!

The Kennedy Forum's Parity Registry website is a helpful resource for locating the applicable regulator. By clicking on the resource tab and then selecting the correct state, one will find a listing of most federal and state regulators, along with other helpful resources.

REGULATORS: WHEN CAN THEY HELP?

Let's assume that your neighbors are playing very loud music late at night. Most people would contact the neighbors and politely ask them to lower the volume of their music. Hopefully, the neighbors will apologize, say that they did not realize they were bothering you, and turn down the music. If you called the police as soon

as the music starts--without speaking with the neighbor first--it may damage your relationship with them. Furthermore, the police will likely ask if you have already spoken directly to your neighbor and provided them a chance to respond. If you have not, the police may suggest you start by speaking directly to your neighbor before they will get involved.

If you have spoken to your neighbor, however, and they have not turned down the music, then you may need to call the police for help. Similarly, if you find that your neighbor turns up the music every other night and you have to continuously ask them to turn it down, or you start to get the sense that they are doing it on purpose to bother you, then you may need to make a more formal complaint to the police and enlist their help. If you do so, you will want to provide them with all of the information about what has happened thus far – what the neighbors did, when the problem happened, what steps you took, etc.

Now think of the insurance regulator as the police.

- If a member/provider has made a good faith effort to work directly with an insurer, have followed their policies and procedures, and have given them a chance to respond or correct a mistake, but the insurer still does not seem to be "playing by the rules," then the member/provider can contact the regulator for help.
    - For example, if an insurer is not answering complaints or appeals within the specified timeframe, is not responding to requests for information, or their responses are inadequate, a member/provider can contact a regulator. If a member/provider has followed the processes that the insurer has outlined in the SPD, but the insurer is not responding as outlined in the contract, a regulator should be contacted.
- If a provider notices a pattern of seemingly unfair practices or a troubling trend that shows the same apparent violation across multiple patients, they can contact the regulator for help.
    - For example, if an insurer carves off 10% of the requested treatment hours for every patient regardless of the patient's clinical presentation, that starts to feel like the loud music being turned on every night.
    - **Note:** It is difficult for members to identify potentially problematic trends. Providers have a unique perspective regarding long-term and common practices utilized by insurers, and they have access to multiple data points that can help regulators identify trends. These insights and data can be used

by regulators to determine if there is a larger, systemic issue with a particular insurer that can, in turn, lead to regulatory action and may even help the regulator prove a parity violation (discussed below).

Unfortunately, a member/provider cannot contact a regulator for help just because they do not like an insurer's response or answer (for example, if an insurer does not approve a medication when an equally as effective and less expensive medication is available). Any complaint to a regulator must cite how the member/provider believes the insurer is acting illegally or unfairly.

REGULATORS: HOW DOES IT WORK?

As noted above, different types of health insurance are regulated by different agencies. While these agencies may be organized a little differently, each agency has a Consumer Services Department that exists to help support and solve problems that an individual member (or their Authorized Representative) is experiencing. Those departments generally need to receive a complaint to begin an investigation and take action.

In most cases, the member must make the complaint against the plan, but a provider can have the member complete a letter that designates them as the member's authorized representative. As previously mentioned, many insurers and regulatory agencies have specific authorized representative designation forms that must be used. Once a member completes one, the provider is then able to act on the member's behalf to submit complaints/appeals or ask for information directly.

Once the consumer services department has received a complaint, the regulators will work to resolve the individual case presented to them by coordinating between the member (or the provider acting as the Authorized Representative) and the company. They will review the complaint and documentation that was submitted, and then they will contact the insurer, share the complaint with them, and ask for the insurer's perspective on the complaint.

The entity that the regulator contacts will depend on the plan type. In the fully-insured market, the state regulator will connect with the insurer directly. For self-funded plans, the U.S. Department of Labor (DOL) staff will either contact the employer or the TPA, depending on the issue. Since the employer holds the fiduciary responsibility for a self-funded plan, if there is an issue with the policies of the plan, the DOL will contact the employer. For self-funded plans, patients should be prepared for the employer to be involved which may create an uncomfortable

situation for an employee. If the issue is with how the TPA administers the plan/benefits, and a pattern can be shown across multiple employers, the DOL will likely investigate the TPA on a larger scale. Those types of cases can take quite a long time and will likely be considered confidential – even from the person who submitted the complaint that triggered the investigation.

Once the consumer services department gathers information from both the member/provider and the insurer about the situation, they will determine if the action of the insurer or the decision made by the insurer was in line with the plan's coverage and in compliance with the required laws. If the insurer's actions were in line with the coverage and it abided by all laws, then there may be limited options for the member/provider. If the benefit determination or process proved to be incorrect or illegal, then the regulator will instruct the insurer to take corrective action. The regulator will communicate, often in writing, with the impacted parties in terms of the corrective actions that need to be taken. The regulator also sometimes will follow-up with the individual, provider, or advocate who filed the complaint to give them an update regarding the next steps including any remediation measures or the final resolution. This process will be driven by the timelines and rules that have been established in the state, so the involved parties must be patient. If a member is using an authorized representative, the member may want to confirm that communications will be sent directly to the authorized representative. If the company or regulator refuses to communicate with the authorized representative, then the member will have to make sure to share communications with the authorized representative.

Consumer services departments often look for patterns or practices and if a state insurance department finds such a pattern for similar complaints about one insurer, they may expand their investigation and/or refer the insurer to another regulatory enforcement division, the state attorney general, or another similar department for further investigation or legal action. If DOL staff see multiple problems across employers that have contracted with the same TPA, they may take a closer look at the TPA to ensure compliance. Providers have multiple data points that can support patterns of behavior, whether it's the same patient having to go through reconsideration time after time, or multiple patients experiencing the same issue with the same insurer or TPA. While the member/provider can offer the data, and the regulator may welcome the information, the referral and any following investigations will likely be confidential, so the regulator may not be able to give you any information or status updates.

KEY LAWS AND REGULATIONS

In order to know whether insurers are playing by the rules, providers must know what the rules are. There are several laws that govern insurers and protect plan members. This section gives a high-level overview of the key laws that impact commercial insurance plans and protect the rights of individuals who are seeking treatment for mental health conditions—with an emphasis on autism.

UTILIZATION MANAGEMENT

Most of the tips and insights in this guide are based on state and federal laws adopted to govern utilization management transactions. As mentioned above, utilization management is the process by which insurers and TPAs determine whether a benefit or given level of care will be covered (i.e., reimbursed) based on whether they believe it is medically necessary per plan guidelines. Since there are financial incentives for insurance plans to limit care, laws and regulations have been enacted to protect consumers.

UM laws and regulations include provisions for topics such as:

- Clinical review protocols
- Prohibition against financial incentives
- Delegated oversight
- UM reviewer requirements
- Processes related to adverse benefit determination
- Notification and disclosure
- Quality assurance
- Standards vs expedited reviews
- Appeals
- Timelines

ACCREDITATION

In addition to laws that govern UM practices, many insurers are accredited by a national accreditation organization which has standards for the UM processes used. The three main accreditation organizations for health plans are:

- Utilization Review Accreditation Commission (URAC) is an independent, nonprofit organization that promotes health care quality through its accreditation programs. Most major health insurers maintain URAC accreditation.

- National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to assessing and reporting the quality of health plans.
- Accreditation Association for Ambulatory Health Care (AAAHC) is the leader in ambulatory health care accreditation but also accredits health plans.

Each accreditation organization maintains an online directory of the insurers they accredit. A relevant state's department of insurance may also be able to provide accreditation information on a specific plan.

While these accreditation agencies do not make their quality standards publicly available, providers can still cite the requirements of URAC, NCQA, and/or AAAHC accreditation when holding health plans accountable for UM practices. In general, the accreditation agencies follow standards similar to state UM laws. When a provider suspects that an accredited health plan's practices deviate from the type of quality standards that are expected, they may want to consider filing a grievance with the applicable accreditation agency.

STATE LAW: UTILIZATION MANAGEMENT REGULATIONS

Most states have enacted protections for consumers whereby insurers must meet requirements that govern how UM decisions can be made and how denials are handled. These state laws apply to all state-regulated plans (e.g., fully-insured plans). As of 2022, 47 states regulate one or more activities associated with UM. The three states that do not regulate UM functions are Florida, Utah, and Wisconsin. In addition, the District of Columbia and the majority of U.S. Territories (American Samoa, Guam, and the U.S. Virgin Islands) do not regulate UM. In those states, a provider would have to rely on the federal regulation.

Modern-day state UM laws emerged in the late 1980s and national standards were established by URAC and the National Association of Insurance Commissioners (NAIC) in the early 1990s. Many states' UM requirements mirror portions of the Utilization Review and Benefit Determination Model Act issued by NAIC.

Providers should be knowledgeable about the UM laws and regulations for the states in which they operate, and for states that govern any plan for which they are managing a dispute. RegQuest is an online, easy-to-use research tool that outlines the UM laws for each of the states that currently have them. Users must create an account, but there is no charge.

In addition to the state laws related to UM that apply, the ACA requires all plans

sold on a health exchange to be accredited by one of the accrediting bodies listed above.

Since state UM laws vary, this guide uses federal regulations (the next section below) as a framework for what may also be found in state law and in most accreditation standards. Federal law includes most of the protections discussed in this guide in the section titled Appeals: Responsibilities of the Plan, such as the required timeframes for responses, the requirements for how coverage decisions are made, and appeal rights.

FEDERAL LAW: ERISA'S UTILIZATION MANAGEMENT REGULATIONS

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards that employers must follow if they offer retirement and health plans. It was written to protect the rights of the employees who receive benefits through employer-provided health plans.

ERISA applies to both self-funded and fully-insured employer plans (i.e., group plans), although employers such as government agencies, the military, and religious organizations are usually exempt. ERISA does not apply to individual plans, nor does it apply to most government-backed plans.

ERISA mandates that an insurer has a fiduciary responsibility to administer the plan on behalf of the participants, not to make money for itself or the plan sponsor. In short, an insurer cannot deny medically necessary services just because those services cost "too much."

Most relevant to this guide, ERISA specifically includes regulations related to UM practices in its Claims Procedure section of the federal regulations. See Appendix A: Reference Links to Key Laws for a link to the Claims Procedure section of ERISA.

HOW & WHEN CAN A PROVIDER USE UM RULES & REGULATIONS IN AN APPEAL?

Reminders about the types of appeals:

- Remember that a medical necessity denial is typically handled through an internal UM appeal process—sometimes with two different internal levels—and then, if pursued, an external review appeals process.
- Remember that a coverage or administrative denial is handled through a

grievance or complaint process with often no rights to an external appeal.

Assessing how the appeal process is regulated:

Your appeals pathway will vary depending on how the policy is regulated. There are three major sources of regulations—

- Federal regulations (including the U.S. DOL Claims Regulations and the ACA);
- State regulations (including state UM, external review and grievance procedure laws); and
- Accreditation standards (including URAC, NCQA and AAAHC).

Other regulations may exist to depending on the specific program or policy requirements.

Determining which regulations apply:

The SPD's of some plans include information about how the plan is regulated, but it's not required.

So, the best use of your time is probably to contact your state insurance regulator to find out whether the policy in question is regulated by the state. If that is the case, the regulator can help explain the state-based appeals process and refer you to the applicable regulations. You also can find the state-based regulations on the state's insurance department's website or through RegQuest.

- For a general list of regulators and consumer advocates/ombudsmans by state, see www.parityregistry.org/resources/.

If you hear from the state insurance regulator that the state does not regulate the policy in question, or you know that it is a self-funded policy, then you'll be looking to federal regulations.

- ERISA's Claims Regulations will more than likely provide you some key touch points. You can try to reach out to EBSA at the U.S. DOL but UM issues are not its focus.
- If the policy is a Medicare plan, contact the U.S. Centers for Medicare and Medicaid Services (CMS).
- If the policy is a Medicaid plan, contact CMS or the state Medicaid department.

Identifying what accreditations apply:

If you feel like the insurer is not handling your appeal properly, you are encouraged to file a complaint with the plan's applicable accreditation organization.

In most case, the insurer also will be accredited by either URAC, NCQA or AAAHC. The best way to find out which organization has accredited the plan is to look at each organization's online accreditation directory:

- For URAC, see www.urac.org/directory/accreditations/
- For NCQA, see reportcards.ncqa.org/health-plans
- For AAAHC, see eweb.aaahc.org

MAJOR TAKEAWAYS:

Even if you cannot figure out how your plan is regulated or you are not sure which specific appeal rules apply, keep in mind that you can hold the health plan accountable on several core principles, which include:

Appeals Process - Insurers must explain the appeals process to you through the plan documents and in writing when a denial of care is made.

Timeframes - Any appeal needs to be handled on a timely basis. Expedited appeals typically need to be handled in 2 days; and standard appeals need to be typically handled within 30 days. Check out RegQuest for more detail list of timeframes.

Denial Disclosure - The reason for the denial needs to be disclosed with some explanation, which should include the specific review criteria or policy terms used in making the adverse benefit determination.

Parity Disclosure - The insurer must respond in 30 days pursuant to MHPAEA for a mental health parity request, where the insurer must provide information about how the mental health coverage matches up to a medical/surgical analogue.

Additional Documentation - You should have the right to send to the insurer additional documentation supporting your request for coverage when appealing a denial of care.

Medical Specialist Review - After an initial adverse benefit determination, plans must have the denial of care reviewed by a medical specialist in the same areas as the requested care that was denied.

Written Communications - The insurer must update you on the appeals process through written correspondence.

MENTAL HEALTH PARITY

THE FEDERAL PARITY LAW (A.K.A. MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (referred to as MHPAEA and the Federal Parity Law) requires that insurers offer parity between the limitations applied to mental health and substance use disorders (MH/SUD) and the limitations applied to physical health (medical conditions or surgical procedures -- Med/Surg). MHPAEA is a critical anti-discrimination law meant to prevent insurers from making it more difficult for members to access treatment for mental health and substance abuse disorders than it is to access treatment for physical/surgical conditions. When originally written, MHPAEA applied to all employer-sponsored, large group plans (both fully-insured and self-funded). MHPAEA protections were then extended to small group and individual policies through the Affordable Care Act (ACA).

While MHPAEA has a simple concept – don't discriminate when it comes to services for mental health and substance use disorder treatment and services – the regulations are complex and there is still a lot of work to be done by providers, advocates, regulators, and insurers to ensure compliance and enforce this important law.

Since autism spectrum disorders are a mental health condition, (it is defined in the Diagnostic Statistical Manual, 5th Edition which defines all mental health conditions), MHPAEA is a powerful tool that the autism community can use to make sure individuals with autism are treated fairly in accessing medically necessary treatments. (Note: insurers occasionally try to define ASD as a medical condition instead of a mental health condition to avoid the requirements of MHPAEA. If a provider encounters that issue, they will likely need help from a lawyer or advocate. See the section titled Who Can Help).

MHPAEA: Treatment Limits

Treatment limits are fees or other restrictions that limit a patient's ability to access services. MHPAEA requires that there be parity in how treatment limits are applied to Med/Surg and MH/SUD benefits. There are two major categories of limits outlined in MHPAEA:

Quantitative treatment limits (QTLs)

- Cost-sharing – deductibles, copays, coinsurance, out-of-pocket limits
- Visit limits
- Note: A limit with a "number" is a QTL.

Non-quantitative treatment limits (NQTLs)

- UM standards based on medical necessity
- Fail first policies (the practice of requiring that the patient utilize lower-cost therapies which are usually less effective before accessing the preferred treatment)

Restrictions that limit the scope or duration of benefits such as those based on location, facility type, or network adequacy.

EXAMPLES OF LIMITATIONS IMPOSED ON ABA TREATMENT BASED ON A SURVEY OF A NATIONAL GROUP OF ABA PROVIDERS:

QUANTITATIVE TREATMENT LIMITS (QTLS):

- Lifetime or annual dollar limits
- Lifetime or annual visit limits

NON-QUANTITATIVE TREATMENT LIMITS (NQTLS):

- Medical necessity guidelines
- Limits based on parental involvement
- Excessive diagnostic or authorization requirements (such as repeated testing or specific tools/measures to confirm the diagnosis)
- Excessive treatment plan requirements (e.g., the treatment plan must be transcribed onto their form, a specific measure such as the Vineland must be used.)
- Limits on service location (e.g., in school or community)
- Limiting treatment based on too much progress or too little progress (when progress can still be made), rate of progress, or duration of treatment

As mentioned earlier, MHPAEA requires that insurers offer "parity" between the limitations applied to mental health and substance use disorders (MH/SUD) and the limitations applied to physical health (medical conditions or surgical procedures -- Med/Surg). Analyzing whether parity exists is a pretty complicated process, especially when we're looking at NQTLs. Regulators are the experts, and you should rely on them for their expertise. But they need you, because you're on the front lines, to point out where you suspect parity violations to exist.

Here's an overview of the parity analysis so that you get an idea of its considerations. To determine whether a health plan is treating Med/Surg benefits on par with MH/SUD benefits, there will be analysis of the MH/SUD benefit limitations to ensure that they do not exceed at least two-thirds of the Med/Surg benefit limitations.

To be compliant with Federal Parity Law, insurers cannot show parity between just two services – e.g., between ABA and speech therapy. The comparison must be done between all Med/Surg outpatient services and all outpatient MH/SUD services. Another example, if prior authorization is required for outpatient SUD treatments but not for outpatient medical treatments, parity may not have been met. Federal parity law does not say that a plan cannot impose limits, just that if it does impose limits, those limits must be consistent across MH/SUD and Med/Surg benefits within the same service category (there are six service categories but the most relevant ones for those with autism are outpatient in-network and outpatient out-of-network). Keep this in mind: There are relatively few limits on the Med/Surg treatments, so limits imposed on MH/SUD treatments are often a violation.

Before imposing treatment limitations, it is the responsibility of the insurer to complete all MHPAEA required parity analyses. And then the regulators are responsible for reviewing those analyses for compliance with parity laws. While familiarity with the laws and protections is critical for providers and patients to protect themselves and report warning signs when they see them, it is not the responsibility of providers and members to prove there is a MHPAEA violation.

The DOL has issued many guidance documents on MHPAEA. Here is a useful document about treatment limits and MHPAEA. And this guidance identifies "warning signs" that parity requirements may not be being met.

MHPAEA: Disclosure Requirements

In addition to setting rules for the types of limitations imposed on MH/SUD benefits, the other powerful component of MHPAEA is its disclosure requirement. Insurers are required to disclose and provide in writing all of the following upon request:

- For a denial of coverage / adverse determination:
    - The specific reason(s) for a denial/adverse determination
- For compliance with federal parity law
    - A parity analysis
    - The medical necessity criteria/guidelines used to make the specific coverage decision

How and When Can a Provider Use MHPAEA?

In the **Common Problems** section of this guide, we cite instances when a provider may want to invoke MHPAEA. **While patients and their providers can share examples of potential MHPAEA violations with regulators, it is not the responsibility of an individual or provider to prove the violation.** The regulator must do that, and most will appreciate the information collected by providers in pursuit of a MHPAEA investigation.

Here are a few ways MHPAEA may be helpful to providers, and in turn, helpful to regulators:

- Required disclosure of the medical necessity criteria used to make coverage decisions, and the specific denial reasons for each patient.
    - When faced with medical necessity denials, providers can request the specific medical necessity criteria that were used to decide the case, and also the specific reason the denial was made. If provided, the criteria will often be more specific than the insurance plan's publicly available medical policy for ABA. Knowing the medical necessity decision criteria and how it was applied to a patient (i.e., which criteria were not met) will allow a provider to better refute the decision and explain why the patient meets those criteria. For example, if an insurer denies treatment based on the progress made to date by the patient, then having the specific criteria may allow the provider to demonstrate how the progress made does meet the criteria.

- Required disclosure of the parity analyses conducted to ensure compliance with parity laws.
    - Should a provider find themselves in a situation where they believe there may be a MHPAEA violation, federal law allows them to request information about the insurance plan's treatment limitations that may affect access to MH/SUD benefits, as well as the parity analysis that was conducted by the insurer.
        - Requesting this information says "SHOW ME that you have taken this law seriously and are being fair to patients with mental health disorders."
        - **Also, requesting it shows an insurer that the provider knows what they are talking about!**
        - Upon receipt of the request, the insurer must provide the information within 30 days. Many plans do not respond to this request which is an opportunity for providers to report the practice to the regulator.
        - See the section titled Submitting a MHPAEA Disclosure Request and Reporting Non-Compliance for guidance on managing this process.

If a provider suspects that MHPAEA rules are being violated, they can file a complaint with the plan's regulator. The regulator can investigate the situation, will ask the plan for their parity analysis, and instruct the plan to remove any illegal limitations that were discovered.

See Appendix A: Reference Links to Key Laws for links to the relevant sections of MHPAEA.

STATE PARITY LAWS

In addition to the Federal Parity Law, states also have parity laws that regulate plans subject to state law. Details about the specifics on each state's parity law have been compiled by The Kennedy Forum:

- There is a page that lists key laws, regulations, and enforcement actions specific to each state in the Reports section of its Parity Track webpage.
- Additional consumer and advocacy resources are available via the Resources of the Kennedy Forum's Parity Registry webpage.

In addition, The Kennedy Forum blog provides interesting updates about both federal and state parity issues.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

The Patient Protection and Affordable Care Act of 2010 (a.k.a. the ACA, Obamacare) is a federal law that, among other things, provides rights and protections to health care consumers. Most of the rights and protections apply to all health plans, a few apply to only employer-sponsored plans, and a few others apply only to individual plans sold through a health insurance marketplace (either a state-run marketplace like Get Covered NJ or Washington Healthfinder, or the federal marketplace HealthCare.gov), with the help of an insurance broker, or directly from the insurer (often through their website). As mentioned earlier, there are a small number of grandfathered plans—as well as alternative insurance products— that are excluded from many of the provisions of ACA.

The most important ways that the ACA impacts coverage for autism are:

- Granting additional protections to providers and consumers of all ACA-governed plans related to internal and external appeals, including the right to an external appeal for medical necessity denials.
- Allowing parents to purchase a child-only policy regardless of the child's health status. This is useful when a parent's employer-sponsored plan does not cover ABA but individual plans sold in the state do.
- Requiring most fully-insured individual and small group health plans to cover MH/SUD benefits as Essential Health Benefits. If a state includes ABA as a benefit in its chosen "benchmark plan," then all fully-insured small group and individual policies in the state must also cover ABA, even if not required to do so by the state's autism insurance regulations.
    - This does not mean that all fully-insured small group and individual plans cover ABA. Although these plans must cover MH/SUD disorders, they only need to cover ABA if it is mandated by state law or included in the state's ACA "benchmark plan."
    - Self-insured employer plans are not required to cover the Essential Health Benefits, including MH/SUD services, but if they do, then MHPAEA applies.

- Forbidding annual or lifetime dollar, visit, or duration limits on ABA if it is included in a plan as an Essential Health Benefit.
    - **Note:** Even if ABA is not an Essential Health Benefit in a state's "benchmark plan" but only included because state insurance law requires it, lifetime and annual limits on ABA in fully-insured plans are likely prohibited by MHPAEA.
- Requiring that MHPAEA protections apply to individual, small group and Medicaid managed care plans in addition to large group plans. See the MHPAEA section for more information.
- Prohibiting discrimination in benefit design or policies based on federally protected categories, such as disability, age, health status, and gender. This means that an insurer cannot design their plan so that a person in one of those protected categories would not want to buy that plan over other plans. This principle is often referred to by its location in the ACA –Section 1557.
- Strengthening continued coverage provisions. See the next section for details.

See Appendix A: Reference Links to Key Laws for links to the relevant sections of the ACA.

THE ACA'S CONTINUED COVERAGE PROVISIONS

An important element of the ACA is its language about **Continued Coverage** during an appeal. Continued coverage protections are available for "concurrent authorization" requests (i.e., authorizations to extend care while treatment is already underway), which is why it is important to request the correct type of authorization. **Note: The course of treatment is based on the duration of the treatment plan not the authorization increments (often six months) of the insurer.*

Under continued coverage protections, if a patient is in the course of an ongoing treatment, then an insurer cannot reduce or terminate the treatment without providing advance notice and a sufficient opportunity to appeal. The plan should maintain the level of care (as previously authorized) during the course of the appeal.

This is how it's supposed to work: if a patient has been receiving 35 hours/week of authorized services as part of a treatment plan (which for ABA, is usually several years long) and then, for the next authorization period, the insurance plan denies 10 hours and only authorizes 25 hours/week of treatment, the insurer must maintain the authorization at the previously approved 35 hours/week until the appeal process is complete.

Usually, health insurers do not proactively offer to maintain the higher level of care when issuing an denying or reducing hours for a concurrent authorization. Instead, they simply notify providers and members of the adverse determination and then implement it as soon as the current authorization ends.

In an appeal letter, a provider should include a statement requesting that the previously approved authorization level be kept in place during the duration of the appeal. As with all other violations of consumer protections, a regulator complaint should be submitted if the insurer refuses to abide by this law.

Requests for continued coverage can cite the continued coverage provisions of the ACA as quoted below:

> 45 CFR § 147.136 provides:
>
> **(iii) Requirement to provide continued coverage pending the outcome of an appeal.** A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that **benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review**.

See Appendix A: Reference Links to Key Laws for links to the relevant sections of the ACA.

STATE SPECIFIC AUTISM REGULATIONS

All fifty states have a law or regulations that require state-regulated insurance plans to cover the treatment of autism, including ABA. The laws for each state differs—some require coverage in all plans (state-regulated large-group and small-group plans plus individual plans), some in just large group plans, some include the state employee plan while others do not, some have age caps, etc.—so providers should always read the regulations of the autism insurance mandate in the contract state of the plan (versus the state in which services are provided) to understand what protections exist.

In some cases, the autism insurance mandate/regulations in a state may be used to appeal an adverse determination. For example, the autism insurance law in Maryland requires insurers (for fully-insured plans) to cover a minimum number of hours of ABA per week and forbids them from denying treatment just because

it is provided in an educational setting. If a treatment denial for a Maryland-based plan violates the minimum standards of the state law, then a provider can make a complaint to the state regulator, the Maryland Insurance Administration.

There are two organizations (and perhaps others) that have compiled information on autism-related state insurance laws (often called **autism mandates**).

- **The Kennedy Forum's Parity Track:** www.paritytrack.org, select Parity Reports from top of the screen, then select a state, and choose Overview tab. Scroll down to the Autism section.
- **Autism Speaks:** www.autismspeaks.org/state-regulated-health-benefit-plans, scroll down and select a state.

As you research state autism insurance laws, keep in mind the following: It is common to find out that many of the exclusions or limitations that are found in state insurance laws related to autism are not being enforced (because it has been determined that they are discriminatory). So if you see age, hour, or dollar caps in the state law (or even quoted in an SPD), don't assume that they're being enforced and that the patient is limited by them. They may be obsolete. How can you find out if the limitations are currently being enforced? You'll likely have to do some research because organizations are understandably wary about publicly stating that a state's law is not being followed. So how can you find out? Some source suggestions: other providers, the relevant state's ABA/BCBA association, CASP, Autism Speaks, autism/ABA/insurance billing groups on Facebook.

CASE LAW: WIT V. UNITED BEHAVIORAL HEALTH SOLUTIONS

Wit v. United Behavioral Health Solutions has the potential to be landmark federal court ruling that will help patients have access to the health care they need. Issued in 2018, the Wit decision concerns medical necessity decisions made by insurers for MH/SUD services. In short, the court found that UBH's medical necessity decision-making process was driven by financial reasons (i.e., to save money) instead of being made in the best interest of the patient, and therefore was a violation of UBH's fiduciary responsibility under ERISA. This was a class-action lawsuit and the court found evidence that UBH had been using its defective medical review criteria to reject claims for tens of thousands of patients seeking MH/SUD treatment. The court determined UBH's Level of Care Guidelines and Coverage Determination Guidelines—its internally-developed guidelines for making medical necessity decisions—were more restrictive than **generally accepted standards of care. This**

phrase—generally accepted standards of care—is one all providers should be familiar with because any time an insurer deviates from industry-wide patient-centered common practices, providers should be on alert for violations of consumer protection laws or accreditation standards.

Although the district court's ruling has been reversed on appeal—as of the publication of this document—the Wit decision has already had a positive effect by fleshing out a set of principles for how medical necessity decisions should be made for MH/SUD coverage. Two states have incorporated these principles into state law—California and Illinois—and others are preparing to follow. Additionally, it is likely that the Wit reversal will be reconsidered or appealed, so the lower court's ruling in favor of the Wit plaintiffs could be reinstated and serve as case law to guide future court decisions.

The Wit opinion identified eight principles insurers must follow when covering MH/SUD services. Below each principle, we have identified examples of how they could apply to ABA medical necessity reviews.

1. **Treat the underlying condition and not just the current symptoms.**
    - E.g., Insurers should not reduce treatment if progress has been made on some goals, assuming the symptoms of ASD still exist
2. **Treat the co-occurring conditions.**
    - E.g., The insurer cannot deny treatment for a co-occurring medical condition by determining that it is related to the child's autism diagnosis, even if ABA is excluded from coverage. Examples include speech or sleep disorders, GI problems, and others.
3. **Treat at the least intensive level of care that is safe and just as effective as a higher level of care** (cannot sacrifice effectiveness because a treatment is equally safe).
    - E.g., Insurers should only require less intensive treatment or dosage if they can show that it is just as effective.
4. **Err on the side of caution by using a higher level of care when there is ambiguity.**
    - E.g., When in doubt, insurers should approve more hours, not less.
5. **Include treatment services to maintain function and prevent deterioration/regression.**

- E.g., Insurers should not deny a patient services because the patient is "not making adequate progress" when data shows that the treatment is preventing regression.

6. **Determine duration based on the individual's needs, without arbitrary limits.**
   - E.g., Insurers should not set arbitrary limits on setting, age, hours of treatment, length of treatment, etc.
7. **Take unique needs of children/adolescents into account.**
   - E.g., Approving a sub-optimal dosage in childhood can impede a child's ability to reach their maximum potential in life.
8. **Use a multidimensional assessment to determine the appropriate level of care** (e.g., LOCUS, ASAM criteria).
   - E.g., Consider deficits across multiple domains of functioning and environments in which the child participates

When the autism community believes that an insurer is using medical necessity guidelines that do not align with generally accepted standards of care and violating any of these eight principles, the Wit case can be referenced as support for the insurer's practice being inappropriate and possibly illegal.

Furthermore, since the assumption is that insurance plans approve treatment of Med/Surg conditions in alignment with these principles, then any denial of care for a MH/SUD condition that violates one of these principles could be a violation of the federal parity law—MHPAEA.

For more information about how the autism community can use the Wit decision, we recommend materials created by The National Council on Behavioral Health. Learn more here and by using its toolkit.

WHICH LAWS APPLY?

The type of coverage a patient has dictates the coverage and protections available to them. The following chart is a summary of applicability to help guide your understanding and decision-making in the case of a denial.

In some cases, such as for fully-insured employer plans, both state and federal (ERISA) laws apply. If ERISA law is more protective to consumers than state law, then ERISA will govern. Similarly, if state law is more protective than ERISA, then the state law will govern.

	Fully-funded large group	Fully-funded small group	Fully-funded individual	Self-funded group	Government employee (federal)	Government employee (non-federal)
ERISA	X	X		X		
MHPAEA	X	Per ACA	Per ACA	X	X (through OMB guidance)	X, but may opt out
ACA	X	X	X	X		X
State Law(1)	X	X	X			X (if fully funded)
Main regulator	State dept. of insurance	State dept. of insurance	State dept. of insurance	Employee Benefits Security Admin. (EBSA) at U.S. Dept. of Labor	U.S. Office of Management & Budget (OMB)	If self-funded, U.S. Dept. of Health & Human Services (DHHS)

(1) When a state autism law applies to a plan, that does not mean the law requires the plan to cover the treatment of autism. The law must be reviewed to understand which types of plans are impacted (individual, large-group, or small-group). For example, in some states, the law only requires that large-group plans must cover ABA.

PART 2: THE PLAYBOOK

UNTIL THIS POINT IN THE GUIDE, we have provided background information that all providers should be familiar with to support their patients. Now we have arrived at the heart of the guide: how do we get authorization for our patients, what happens when an insurance company says "no," how can we best respond, and what specific protections can we leverage to assist our patients in accessing recommended care.

The rules and protections listed below are based on federal ERISA law. There are state laws relevant to fully-insured plans that can be found in RegQuest's Utilization Management modules.

DOCUMENTATION

Document everything! Proper documentation is critical to securing authorization for services and following up on any issues. Providers should:

- Track phone calls – the dates and times of calls, the names of the representatives on the calls, any information provided, a reference number for the call.
- Track all submissions – date sent, content, proof of receipt, etc.
    - When mailing, providers should send packages as certified mail with return-receipt requested, and then should save tracking information and confirm receipt.
    - When faxing documents, providers should save proof that the fax was transmitted and received.
- Save all correspondences that the insurer sends related to the authorization.

AUTHORIZATION

As explained in Part I of the guide, authorization is a process by which an insurance plan approves the request of a medical or mental health provider to deliver a service. ABA for the treatment of ASD almost always requires authorization.

MEDICAL NECESSITY GUIDELINES

In deciding whether to authorize services, insurers must have documented guidelines that they use to make decisions. These can go by a variety of names such as Medical Coverage Policies, Medical Review Criteria, Clinical Policies, Clinical Criteria, etc. Regardless of the name, the document should explain what is required for a specific treatment to be considered medically necessary by the insurer.

A key challenge faced in the field of ABA is insurers using medical necessity guidelines that do not align with the **generally accepted standards of care** in the field, which is likely an ERISA violation and possibly a parity violation. Those criteria may then be used to deny treatment that research would predict provides the best potential outcome for the patient. This topic is discussed throughout this guide and specifically addressed in **Common Problems** section titled Medical Necessity Criteria Do Not Align with Generally Accepted Standards of Care.

IS PRIOR AUTHORIZATION REQUIRED?

The most convenient way to check whether prior authorization for a service is required is for a provider to ask when calling to check a patient's benefits. Providers can ask:

- "Is authorization required?"
- "If so, what is the process?"

The most definitive way to check whether prior authorization for a service is required is to look in a plan's SPD. Each SPD should have a section that lists which treatments require prior authorization before they are delivered. If the list changes, insurance companies are required to notify providers.

Because ABA frequently requires prior authorization, and since it is a relatively new benefit for many insurers, providers should always be skeptical if told that a plan does not require prior authorization. There are plans for which this will be true, but a provider should always double-check. Here are some suggestions for how a

provider can confirm whether a plan requires prior authorization if told otherwise:

- Double-check the information by calling back and asking the same questions of another customer service representative. Document each call.
- Follow the insurer's standard process for prior authorization anyway. If the authorization department responds that the plan does not require authorization, then the information is usually trustworthy, and the provider can document that they followed the process.
- Check the SPD! Providers can ask the family to provide the SPD and double-check the list of covered services that require prior authorization.
- For employer-sponsored fully-insured plans, providers can check the insurance company's website for a list of services that require prior authorization and related policies. If a list is found, providers should download the documents or take screenshots that show the entire list of covered services that require prior authorization does not include ABA.
- Request a pre-determination letter with a list of all covered codes from the payor. The pre-determination letter will state whether the requested service is covered, ideally with a list of each covered CPT code (e.g., 97153 is a covered service for this member). Most likely, pre-determination letters will not specify an allowed amount of hours that would be covered, so after the claims are submitted, providers still may be asked to submit documentation to support the number of hours delivered.
    - Providers can ask the benefits department how to submit for pre-determination –where to send the request, what information the payer would like included, and the timeline for response. These are often submitted via fax.
        - The documentation requested may include items such as the patient's diagnosis and potentially a diagnostic report, the CPT codes for the service, and a brief description of the type of treatment being proposed.
    - Once submitted, the request will be processed, and the provider should receive a written response.

**Note: If a patient has more than one insurance plan, providers should request authorization from each plan.*

WHEN AND HOW TO GET A SUMMARY PLAN DESCRIPTION (SPD)?

Having a copy of a plan's SPD is critical whenever there is a need to research plan details or dispute something the plan has done. Some providers ask every patient for a copy of their plan's SPD, while others only ask for it when an issue arises. By having a copy of the SPD, a patient and their provider can review all the plan details and requirements without having to rely on (potentially inaccurate) conversations with customer service representatives at the insurance company.

When a patient requests an SPD, they are often sent the Summary of Benefits and Coverage (SBC) which is typically a 2-3-page document formatted as a table and it will not include the needed information. In that case, the member must ask again and be clear that they would like the longer document. The SPD is usually a 50-100 page document.

For employer-sponsored plans

- An employee should request the SPD in writing from their HR department. Once requested, the HR department is required to provide it to the employee within 30 days or they can be fined for each day they are late (if the case winds up in court).
- Sometimes the SPD can be obtained by logging in to the employer website.
- If an employee is having a hard time getting a copy, they can contact EBSA at the U.S. DOL for assistance.

For individual plans

- If an individual is looking for a plan through a health exchange, the SPD, sometimes called a contract, may be available online on the exchange website or the insurer's website. If not, they may be able to ask the insurer directly for a copy.
- Often with fully-funded plans, one can download the evidence of coverage manual after logging in to the insurance website.
- If the individual is having a hard time getting a copy, the state insurance department may be able to help.

What if I do not request prior authorization for ABA before beginning services?

Answer: ALWAYS confirm whether ABA requires prior authorization and follow the process to request it before delivering treatment. If you fail to obtain prior authorization when it is required, you can ask the plan for a post-service review or to "back date" the authorization. Some plans will allow it, although many do not. If prior authorization is not requested when it is required to be, there will usually be a penalty where either a percentage or all of the claims will be denied.

What happens if I am told prior authorization is not required but then the plan denies the claims due to lack of prior authorization?

Answer: Start by contacting the plan to ask why the claim was denied. A clerical error may be the cause of the denial, and the problem can be cleared up quickly. If the denial is not a clerical error, file an administrative appeal with the plan and show documentation of the process you used to confirm that prior authorization was not required. Once you have filed the appeal, if you are not getting a response, not getting a response promptly, or do not feel that you are getting a "fair" response, file a complaint with the regulator and enlist their help.

HOW DOES THE PRIOR AUTHORIZATION PROCESS WORK?

When prior authorization is required, it must be sought whether the provider is in-network or out-of-network. When in-network, the provider should always obtain prior authorization for services. When out-of-network, the provider should try to call to request authorization. The plan may require the member to make the initial call and then have the provider call to provide clinical information.

For ABA, authorization is usually broken into 2 pieces:

- Authorization to complete an ABA assessment: Often, diagnostic information must be submitted for the ABA assessment to be authorized.
- Authorization for treatment: After the provider has completed an ABA assessment and developed a treatment plan, the provider must then request authorization for the recommended services and treatment hours based on that plan.

Each health plan has a different prior authorization process, which should be outlined in the SPD or the provider contract. The process may include elements such as:

- Submitting an insurer-specific prior authorization form;
- Submitting the diagnostic report;
- Submitting the ABA treatment plan; and/or
- Conducting a call with a reviewer who asks questions about the patient, their symptoms, and the ABA treatment plan.

AUTHORIZATION: RESPONSIBILITIES OF THE PROVIDER

In order to ensure the greatest likelihood of having a patient's treatment authorized by the insurer, a provider should:

- Keep track of and document the entire process.
- Follow the required authorization process promptly.
    - Always ask for information about the authorization process when confirming benefits. Many insurance companies have their own authorization request forms that must be submitted.

- Understand the medical necessity requirements of the plan.
    - Review any published guidelines or criteria that may be available from the insurer for guidance about their requirements. Relevant guidelines may be publicly available on the insurer's website or may be behind a login on the provider portal. Key documents to review include:
        - Medical necessity guidelines and/or clinical criteria: Look in the clinical policy section of the insurer website or portal for any guidelines about subjects including autism spectrum disorder, applied behavior analysis, or intensive behavioral interventions.
        - Additional ABA-specific guidelines, assessment requirements, treatment plan requirements, etc.: Insurers may provide additional documents in an autism/ABA section on their website.
        - Provider manuals: Providers should always review payer manuals as these are included in the contractual obligations of an in-network provider. These manuals will often include information regarding authorizations, treatment plan requirements, and other documentation guidelines.
    - If a provider is having problems finding ABA-specific guidelines from an insurer, they can contact their provider representative and ask for assistance.
    - *Note: Some insurers' guidelines do not align with the generally accepted standards of care for autism, which can result in the insurer denying medically-necessary treatment. See the Common Problems section for guidance.*
- Request the appropriate type of authorization.
    - **Prior authorization for an initial assessment** – providers should request this for approval to complete an ABA assessment and develop an ABA treatment plan.
        - Providers may be asked to submit the patient's diagnostic report.

            Note: Regardless of whether the insurance company requires it, providers should always collect the diagnostic report during the intake process and review it to confirm that the patient has a documented ASD diagnosis. It should be saved in the medical file because it may be requested in an audit.

- **Prior authorization for treatment** – providers should request this before beginning treatment.
    - Authorization requests should include the number of units of each CPT code and the timeframe of the request (i.e., the start and end date of the request).
    - Most insurance plans authorize ABA for a "standard" timeframe of 6-month blocks. As explained elsewhere in this guide, six months is not the length of the treatment plan, just the length of the authorization request.
- **Concurrent review and ongoing authorization** – providers should request a "concurrent review and ongoing authorization" for any additional treatment past the initial authorized period (e.g., when the first 6-month authorization expires). This will grant protections under the continued coverage regulations that requesting prior authorization will not.

- Only request services that are medically necessary and align with generally accepted standards of care for the condition being treated.
    - Tie treatment plans and goals directly to the symptoms of ASD.
    - Ensure treatment recommendations align with the generally accepted standards of care in the field. Be able to support a claim of medical necessity with relevant research, specialty society recommendations, etc. A list of current ABA resources is available in the section of this guide titled Generally Accepted Standards of Care for ABA.
- If a peer review call is required, be prepared. Some plans require peer reviews for all requests, some require it for all requests over a specified number of treatment hours, and others only require it in special circumstances. In a peer review, the treating clinician will be expected to discuss the case during a live phone call with an insurance company representative typically referred to as a **peer reviewer** who should have experience/credentials related to the patient's diagnosis.
    - Have background information available before the call begins:
        - Provider information – e.g., NPI, address
        - Patient information – e.g., member ID number, diagnoses and

dates of diagnoses, any current medications

- Treatment information – e.g., what is being requested and why, coordination of care activities, etc.

- Review all medical necessity guidelines of the insurer ahead of time so that you can explain to the reviewer how the patient and the treatment plan meet the plan's criteria.
- Even if you submitted the full treatment plan, be aware that the reviewer may not have read it before the call.
- For the initial prior authorization of treatment, be prepared to discuss the findings from the assessment and rationale for the recommended treatment dosage, setting, and goals.
- For concurrent authorization of an ongoing course of treatment (i.e., successive treatment periods):
    - Be prepared to highlight progress made by the patient due to the treatment being provided. Or, if the patient is maintaining skills but not necessarily showing progress, be prepared to justify how hours are allowing the maintenance of these skills and a reduction in hours would result in regression or loss of skills. If there is data demonstrating regression following a prior break from treatment, have that available to support the assertions.
    - Highlight any skill deficits or behaviors that still need to be addressed with the patient, especially any behaviors that may pose safety risks to the patient or others.
    - Many plans will also want to discuss parent involvement and progress on any parent goals, coordination of care efforts that are being made, and how you are ensuring treatment goals are not duplicative of IEP goals if services are being provided in a school setting.
- *Note: Depending on the experience of the BCBA case supervisor on the team, ABA provider organizations may want to have a supervisor on the phone also for support. Conducting a successful peer review call is a skill for which BCBAs should be properly trained and supported.*
- Document information about the review call.

- Date and time of the call
- Name and credentials of the reviewer
- Notes from the call (what did the reviewer ask and say?) – Be very watchful to document statements that indicate a maximum number of hours that will be approved regardless of clinical and medical necessity, or anything else that does not align with generally accepted standards of care in the field. If possible, try to write down exact quotes. This information may be helpful in an appeal, or for the broader ABA community to address systemic problems.

- **Never negotiate!!**
  - If asked to alter a clinical recommendation in a treatment plan to a lower number of hours, shorter period of time, different location, etc. so that it can be approved by the reviewer, providers should not agree! If the original request was the true clinical recommendation, providers must stick to it! For example, if a provider requests 30 hours of treatment because it is clinically indicated, but the reviewer says that they can approve immediately if the provider resubmits the request for 25 hours, the provider should NOT agree! The last 5 hours must be officially denied in order to be appealed. The clinician should say no and request a denial letter.
  - If the first-level initial UM representative for the health plan indicates that they will not approve all of the requested treatment hours, a provider can ask for a discussion with a peer reviewer before the final decision is made. Providers may need to call the UM department and ask for this option if it is not immediately offered.
- **Get denials in writing!**
  - Require the plan to send a denial letter for any hours, duration, or location that are not approved. These are all considered adverse determinations. A letter will be needed to appeal the decision. Do not accept a verbal denial.
  - If a provider is notified of a denial or partial denial during a call, they should confirm how and when the denial letter will be sent.

WHAT IF THE PLAN REFUSES TO SEND THE DENIAL IN WRITING?

Submit a complaint/grievance to the insurer on the member's behalf. Per ERISA law, all adverse determinations must be provided in writing. If you still do not get a response, submit a complaint to the regulator.

AUTHORIZATION: RESPONSIBILITIES OF THE INSURER

There are federal and state laws that govern how and when an insurer must reply to requests for authorization. When they do not meet the requirements, they are breaking the law and should be reported to the regulator. The requirements listed below are based on ERISA, a federal law, but for state-regulated plans, state laws also apply, especially when they are more favorable to the member. State laws can be found in the Utilization Management modules at www.regquest.com (you'll need to create an account, but it is free).

PROCESS REQUIREMENTS

- Process: The process for requesting authorization and the required time-frames for responses must be outlined in the SPD. The process must not be **unduly administratively burdensome**, such as having a fee.
- Timeline: The plan must respond to a request for authorization within a set timeframe.
    - For a standard prior authorization or concurrent review request, the insurance administrator must notify the member/provider of the benefit determination (approved or not) within 15 days of the request. For employer-sponsored fully-funded plans, the state law may require insurers to respond even sooner. About 10-15 states require a response within 10 days or less.
        - Members/providers may request an expedited review if the situation is urgent and a faster answer is needed.
    - The plan may ask for a one-time extension in writing BEFORE the deadline if there are circumstances beyond their control. They must explain the circumstance and provide a date by which they will answer.
        - If a member/provider does not receive the request for an extension in writing, they should ask for written confirmation of the

explanation of circumstances and due date. This may come in handy during an appeal process.

- If the insurer believes that the request was not complete, they must ask for more information within 5 days of the submission. The member/provider must then be given 45 days to respond. The notice must specifically describe the information needed for the request to be complete.
    - Providers should respond to the request for information within the 45-day allotted time or cite where the information is contained in the original request.
- If the insurer keeps requesting additional information that the provider does not plan to provide (e.g., an IEP or additional testing), the provider should be clear that they do not plan to provide it and insist that the insurer make the decision with the information already provided and issue a decision letter accordingly.

WHAT IF THE AUTHORIZATION REQUEST WAS NOT COMPLETE (E.G., A FORM WAS MISSING) & THE PLAN DOES NOT RESPOND?

Per ERISA law, the insurer must notify a member/provider if needed information is missing. If the company fails to respond to a request within the deadline, the member/provider should contact the regulator about the process violation, esp. if there seems to be a pattern of abuse.

- Authorization Decisions: Authorization decisions must be made following the plans' provisions and, where appropriate, must be applied consistently to similarly situated claimants.
    - The insurer must have clearly established criteria that it uses to make medical necessity-based authorization decisions. Per MHPAEA, those criteria must be made available upon request.
- Decisions must be made consistently based on specific guidelines. I.e., if two patients have the same clinical presentation, they should receive the same authorization.

- If there is a lot of variability among the determinations being made for different patients with similar needs, or even irregular variations for the same patient, there may be a problem.

ADVERSE DETERMINATION (A.K.A. DENIAL LETTER!) REQUIREMENTS

An adverse determination is any denial of or reduction in hours, location, or length of treatment. Even if a treatment is partially approved, there is still an adverse determination for the part that is denied. When an insurer denies a request, ERISA requires that they meet the following regulations:

- Notifications of an adverse determination must be provided in writing or electronically.
    - If the decision is provided via phone, providers should request it in writing and confirm both the mode of communication and the correct address, e.g., email address, postal address, or fax number.
    - If services are partially approved and partially denied, the insurer should send both an authorization for the approved part and also a notification of adverse determination for the unapproved part.
    - If the provider submits the request for authorization, the adverse determination documents should be sent to the provider. The family should also watch for responses in case the letter is sent to them. If there is no response within the legal timeframe, providers should call the insurance company to ask if the adverse determination letter was sent out, and if so, to where it was sent. If the response was not sent within the required timeframe, then it should be noted for use in a potential future complaint. If it was sent but not received, providers can ask for the letter to be faxed directly.
- Notification of the adverse determination must include:
    - Identifying information including the date of service, provider, and claim amount (if relevant).
    - A statement saying that explanations of the diagnosis and treatment codes are available at no cost upon request.
    - A reference to the specific plan provision(s) on which the determination is based
    - For ABA, insurers will commonly cite their medical necessity criteria.

- **For medical necessity or experimental treatment denials, ERISA requires that the plan provide "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation must be provided free of charge upon request."**
    - In short, the plan must provide a reason why they are making the denial that is more specific than "we just do not think the request is medically necessary."
    - **This is a common issue faced by providers.** Some insurance plans deny the last few hours of a treatment plan without a clear rationale. We provide a step-by-step guide for how to address this situation in the **Common Problems** section titled Insufficient Explanation (i.e., Lack of Disclosure).
    - In addition to ERISA regulations, MHPAEA regulations also require that insurers provide details about how and why coverage determinations are made.
- A description of the plan's appeal process and the related timelines.
- Contact information for any applicable member assistance.

SHOULD I SUBMIT A STANDARD OR EXPEDITED AUTHORIZATION REQUEST AND/OR APPEAL?

When submitting a request for authorization or an appeal, you have the right to request the response either as a standard or expedited request. An expedited request will have a shorter deadline for the insurance plan to answer you and should be made when a decision is needed urgently and quickly.

You must include a clinical justification for why an expedited timeline is needed. Some plans require a letter from a physician as well.

Expedited requests should be used:

- When a standard response timeline will seriously jeopardize the life or health of the individual or jeopardize their ability to regain maximum function.
- When services are being reduced midway through treatment (i.e., during a continuing care request).
- When it would endanger the individual or put them at risk of regressing. Some plans have more stringent criteria for expedited review than others, so it may be helpful to consult the plan manual.

In most cases, ABA authorization requests are submitted with a standard timeline.

APPEALS

As discussed in Part I, there are two main types of appeals:

- Clinical / Medical Necessity appeal – This is used when a member or provider is contesting a treatment or part of a treatment being denied as "not medically-necessary" or "experimental." This is used when clinical judgement is involved and there is a discrepancy between the judgement of the provider and of the reviewer at the plan. If a plan has an ABA benefit, but a reviewer did not approve all or some of the requested treatment plan because, in their judgement, it was not medically necessary, then a member could file a Clinical/Medical Necessity appeal.
- Administrative appeal – An administrative appeal would be used in situations that are not related to medical necessity (i.e., not based on the medical judgement of a reviewer). For example, the Maryland autism insurance regulations state, "A carrier may not deny payment for habilitative services if a treatment goal identifies the location of the habilitative services as the child's education-

al setting." If an insurer denies proposed treatment in a school setting based simply on its location, a provider would submit an administrative appeal and focus their argument on the protections in the regulations.

This section was written with a focus on Clinical/Medical Necessity appeals. However, the general approach and process are relevant for administrative appeals.

THE APPEALS PROCESS

As discussed above, if an insurance plan issues an adverse determination based on its assessment of the treatment's medical necessity, the member has a right to appeal that decision. The medical necessity appeals process (also referred to as a UM or UR appeal) includes two types of review: internal appeal and external review.

- For an **internal appeal**, someone from inside the insurance company (other than the original reviewer or their supervisee) will review the request and any supporting evidence provided and will then either uphold or overturn the adverse determination. Plans may have one or two levels of appeal. The internal appeal process will be outlined in the plan's SPD.
    - For fully-insured plans, state law dictates whether one level or two levels of internal appeal are available and/or required. Employer-sponsored self-funded plans may decide whether one or two levels are available. Sometimes, a second-level appeal is available voluntarily before an external review may be requested.
        - Members must exhaust the required level of internal appeals before they can request an external appeal.
        - Following an adverse determination on the first appeal, members may move to the second level of internal appeal. Second-level appeals sometimes require a panel of reviewers that must meet certain requirements of independence from the initial appeal decision-makers (e.g., panelists cannot be subordinates of the first-level reviewer who made the adverse decision).
    - Occasionally, a plan will voluntarily send a case to an independent reviewer. This is not the same as an external review. It is done primarily for their benefit, not the members. The member will still have the right to an external appeal later in the process if the independent reviewer upholds the adverse determination.

- *Note: In ABA, it is very common to lose on the internal appeals. Members/providers must continue the process through the external appeal level, where they obtain an objective outsider's opinion. If second-level internal appeal is optional, you may want to go directly to external review to save time.*

- For an external review, the case is reviewed by a third party, independent review organization (IRO) and the decision is binding on the plan.
    - See the section titled External Review below for more information.
    - External review is guaranteed under the ACA for all medical necessity appeals but is not guaranteed under the ACA for administrative appeals.

APPEALS: RESPONSIBILITIES OF THE PROVIDER

Having the best chance of success in an appeal depends on members and providers following the process correctly, which includes submitting the proper documentation in the packet sent to insurers. This section provides tactical steps to help with that.

PROCESS TIPS FOR SUBMITTING AN APPEAL

To ensure the greatest likelihood of a successful appeal, a provider should:

- Keep track of, and document, the entire process.
- Notify the patient of the adverse determination, their right to appeal, your intention to appeal, and the rationale behind your recommendation to appeal.
    - Members have more appeal rights than providers, so it is CRITICAL that the appeal is submitted not from the provider, but on behalf of the member.
        - To act on behalf of the member, the provider must become an **Authorized Representative** by completing the plan's authorized representative form, which is usually available online. Even if the provider has an assignment of benefits form on file from the intake paperwork, the insurer-specific form should be completed and included with the appeal packet. Many insurers will not review the appeal without it.
    - Confirm the patient's willingness to participate in the appeal process

as needed. If the provider is managing the process, the patient will still need to be involved in multiple ways:

- By completing a plan-specific member appeal form, if required by the plan.
- By completing an authorized representative form to allow the provider to act on their behalf.
- By obtaining a copy of the SPD for the plan.
- By regularly checking their mail and providing copies of communications in case responses are sent to them instead of to the provider.
- If appropriate, by seeking additional letters of support from other professionals, (e.g., a Developmental Pediatrician, Psychologist, etc.).

- If the family is managing the process, the provider will still need to provide a letter with the clinical rationale for the appeal.

- Review the plan's SPD to understand:
  - The type of plan (fully-insured or self-funded, group or individual) and therefore the regulator and the laws that apply.
  - The plan's benefits for ABA.
  - The plan's definition of medical necessity.
  - Any limitations or exclusions in the plan – if the denial is based on a plan exclusion, then a regulator complaint may be an extra important step in the process.
- Determine the correct process for submitting the appeal and follow the instructions provided by the insurer.
  - If a member/provider does not follow the outlined process, they may lose some of the protections that it provides.
    - If a member/provider does follow the process but the insurer does not "play by the rules," they should file a process complaint with

both the plan and the regulator. For example, if the adverse determination letter says, "please send a letter or Form X", but then the insurer does not respond to an appeal because they judge it as incomplete without Form X, then the member/provider can file a complaint and explain to the regulator that they followed the insurer's outlined process yet did not receive a response.

- Identify the timelines for submission (and meet them!) and responses, the number of levels of appeal granted/required, the forms required, and where/how the appeal should be submitted.
    - By federal law, insurers must allow 180 days to submit an appeal from the date of an adverse determination. Some plans will allow up to a year.
    - For state-regulated plans, visit the Utilization Management modules at www.regquest.com to review the timelines, as they may vary. Remember, the rule that is most advantageous to the member will govern.
- Review the adverse determination letter. By law, it must include the appeal process. Processes may vary even with the same insurer, so do not assume the process is the same for every member. Read each letter!
- Review the plan's SPD for additional guidance on how to submit an appeal. If it conflicts with the process in the adverse determination letter, then contact the appeals department to clarify the correct steps. If there is no contact for an appeal department, ask the authorization department and/or member/provider services. As always, document all calls!

- Gather as much information as possible to understand the insurer's rationale for the adverse determination.
    - If a provider knows the plan's guidelines and how they were applied to the patient, the provider is better able to write an appeal that shows how the member does meet the requirements for the requested level of treatment.
    - Providers should contact member/provider services and/or the UM department and request the medical necessity criteria and "any clinical

guidelines, policies, criteria or scientific literature that were applied in making the decision and how they were specifically applied to the member."

- A phone number for making such requests may be provided in the adverse determination letter.
- If a large policy document is provided, ask for the specific page numbers that were relied upon for the adverse determination decision.
- Insurance plans should have an Authorization for Release of Protected Health Information forms. A member can complete it and ask the insurer to release their full case file (i.e., all records) to the provider.

- If the plan offers the option for a post-denial peer-to-peer review and reconsideration, then do it. This additional review is required by some state laws and UM/UR accreditation organizations like URAC and NCQA. This call would allow a provider to discuss the decision with the original reviewer and re-present the case. If the plan tends to change their decision each time a reconsideration is requested, that is also a red flag that there is a systemic problem and could be used in a regulator complaint.
- By requesting information, the provider is not only gathering useful information, but is also verifying that the plan appropriately follows both ERISA and MHPAEA disclosure laws. If the plan violates either law, it can be included in a complaint to both the plan and the regulator. By law, insurers are required to explain the rationale for the decision.
  - ERISA requires the insurer to provide "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation must be provided free of charge upon request."
  - MHPAEA requires that an insurer provide the medical necessity criteria used to make a coverage decision and also the specific reason a denial was made for a member.

- Review the information provided in the adverse determination letter and/or in

the additional information to understand:

- Does the decision clearly explain the scientific justification for why the decision was made and how the decision was specific to the patient, or does it say something vague such as "The requested treatment is not medically necessary" without providing a rationale?
    - If not, see Common Problems: Insufficient Explanation section.
- Do the medical necessity guidelines that were applied by the insurer align with the generally accepted standards of care in the industry?
    - E.g., Do they deny based on arbitrary criteria (such as location) when evidence shows that the location is the most effective place for the treatment? Do they deny based on parent involvement even when research shows a child can make progress without it?
    - If not, see the section titled Common Problems: Medical Necessity Criteria Do Not Align with Generally Accepted Standards of Care.
- Was the decision predictable, or does the insurer give a different (perhaps inexplicable) answer every time authorization is requested?
    - If the plan does not apply its criteria consistently, it is violating ERISA. This pattern should be tracked and included in a regulatory complaint. Patterns can exist within the same patient (if the insurer keeps authorizing a different level of treatment for the same patient) or across patients (if patients with similar presentations are authorized for differing levels of treatment).
- For fully-insured plans, does the decision abide by all state-specific autism laws?
    - For example, in Maryland, the regulations require that insurers approve a minimum number of hours for anyone with ASD.
    - If the decision violates the law, the provider should submit an Administrative Appeal.

- Submit a complete packet of information with all required forms (see Elements of an Appeal Packet) and track it.
    - Always call member services within a few days of sending an appeal to ensure it was received and that it was complete (i.e., they have all the

documents you submitted and that are needed to process the appeal. Document the call (date, time, name of representative, information received, reference number).

- Track the response deadline. If the insurer does not respond within the required timeframe, the member/provider should contact the insurer to either obtain the decision or understand why it has not been made yet.
    - If the insurer misses the response deadline even though everything was submitted correctly, then a member/provider can submit a complaint to the plan and the regulator.
- If the appeal is unsuccessful, the member/provider should continue the process.
    - Request access to any documents used in making the appeal decision to better understand how/why the decision was made.
    - For subsequent levels of appeal, the documents submitted can be the same as the earlier level. The packet will be reviewed by someone new. A member/provider can simply add a cover letter that states the request is for a higher-level appeal and submit the same information. New information may be added, however, if the first level appeal response raised additional concerns about the medical necessity of the treatment or if plan violated a process requirement in the earlier round, such as failing to address the full concerns in the first response or failing to respond within specified timeframes.
    - If a plan did not respond to the parity disclosure request that was originally sent, then in the second level appeal, the provider should state they are still waiting for the response to their earlier request and note the number of days since that initial request was sent.

ELEMENTS OF AN APPEAL PACKET

- Any appeal forms required by the insurer (e.g., a specific member appeal form).
- A form that designates the provider as the Authorized Representative.
- The patient's Assignment of Benefits form (this should be an element of a provider's intake packet/registration forms).

- An appeal letter from the provider includes elements such as:
    - A statement that the appeal is on behalf of the member with a sentence such, "We are writing this letter to appeal the adverse determination based on Medical Necessity for the request for authorization of ABA services for [CHILD]. We are acting as the Authorized Representative of the member, [POLICY HOLDER], and have attached the Authorized Representative Designation form to this letter (Attachment X)."
    - An explanation of the patient's clinical presentation and why the treatment is medically necessary including elements such as:
        - How the treatment aligns with the generally accepted standards of care for ABA
        - How the treatment meets the plan's requirements for authorization
        - If details on how the guidelines were specifically applied to a patient are available, a discussion of how the provider disagrees with the application of the guidelines to their specific patient
    - A discussion of any violations of the contract provisions or laws that occurred during the authorization process or in the decision rendered. Specific language and advice for common problems are found later in this guide.
    - A request for the credentials and experience of the health care professional who conducted the initial review, the one who conducted the appeal review, and their relationship to each other.
    - If a patient is already in treatment and the insurer is attempting to reduce or terminate the treatment, a request for continued coverage during the course of the appeal. See the section titled The ACA's Continued Coverage Provisions.
- A MHPAEA disclosure request letter
    - See the section titled Submitting a MHPAEA Disclosure Request and Reporting Non-Compliance for instructions.
    - Many denials for autism treatments may be violations of the parity laws. Providers must hold them accountable to this important law!

- A copy of the insurer's adverse determination letter and any files (i.e., the treatment plan) that were submitted with the original authorization request.
- Documents that support the generally accepted standards of care in the field including those listed in Generally Accepted Standards of Care and relevant medical literature that supports the treatment plan.
- Letters of support from other professionals (e.g., the child's developmental pediatrician or the diagnostician), if relevant and available.

TREATING PATIENTS DURING THE COURSE OF AN APPEAL

TIP: If you are able to overturn a decision upon appeal, you will only be able to "recoup" money if you have continued treatment. If you have stopped or reduced the treatment until the appeal is over, then there will be no charges for the insurance company to pay. They will not pay for foregone services. So, if you believe that you will win the appeal and you can afford to do so, continue treatment during the course of the appeal.

CONTINUED COVERAGE UNDER THE ACA

TIP 1: Treatment plans should be written for the patient's total course of treatment, not just for the length of any single authorization period (e.g., 6 months). A provider may identify specific goals that will be focused on during the authorization time period, but they should be put in context of the longer, broader treatment plan.**

TIP 2: Sample language to include in an appeal letter

- Sample language for an appeal letter: "Our patient began treatment on [start date] and is currently in the middle of an on-going course of treatment. Under the continued coverage regulations of ERISA (45 CFR § 147.136), the patient is entitled to maintain the current level of care during the course of the appeal. We respectfully request that [Plan name] issue an authorization that maintains the member's current level of care at [XX level or YY hours/week] until the appeal process has concluded."

TIP 3: During the course of an appeal, be sure to ask for an authorization that matches the "higher hours" from the previous authorization so that you will not have a problem with the claims department during the course of the appeal. Explain to the authorization department that you have a right to it under the **ACA's Provisions** for Continued Coverage.

APPEALS: RESPONSIBILITIES OF THE PLAN

State and federal laws require that an insurer's appeal process must allow for a **"Full and Fair" review**. Below, we describe conditions the insurer must meet in order for a review to meet that standard. If the insurer does not follow these conditions, it would be grounds for filing a complaint or grievance with the plan or the regulator. As a reminder, for fully-insured plans, providers should check RegQuest for additional laws and protections that apply.

- Timeframes: ERISA, for example, requires the plan to meet specific timelines for submission and response to appeals.
    - Members (or their authorized representatives) must have at least 180 days from the notification of the adverse determination to submit an appeal.
    - Insurers must respond within 30 days if the plan has one level of internal appeal, or 15 days at each level if the plan has two levels of internal appeal.
    - Note: if applicable, check out state law timelines as well, in some cases, they may require a quicker timeframe.
- Information: Plan must provide the member with information about their decisions, allow the member to submit supporting information about their position, and consider the information in the decisions. Plan must:
    - Upon request, provide documents, evidence, records, and other information related to the claim.
        - Provide a reasonable timeframe for review of and response to the information provided before the deadline to submit such information.
    - Allow members/providers to submit written comments, documents, records, and other information relating to the claim for benefits.
    - Consider all the information provided by the member/provider.
- Reviewers: Plan must use impartial, qualified reviewers.
    - Any level of appeal review must be conducted by someone who was not the original reviewer or supervised by the original reviewer, and who must proceed without consideration of the original decision, and without any conflict of interest.
    - For Medical Necessity appeals, the claim must be reviewed by a health

care professional who has appropriate training and experience in the field of medicine (or must consult with such person) and must differ from the medical expert consulted in the initial review.

    - The use of an unqualified reviewer should be included in regulator complaints.

  - If the person consulted is not disclosed and upholds the denial, request information such as their name, title, and their credentials.

- Response: The plan must provide the appeal response in writing or electronically.

  - The list of required elements in the appeal response is the same as the items listed under Responsibilities of the Plan for an adverse determination to an authorization request (see above).

  - The following statement must also be included: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

WHAT IF THE INSURANCE PLAN DOES NOT RESPOND TO MY INTERNAL APPEAL WITHIN THE SPECIFIED TIMELINE OR DOES NOT MEET ANY OF THE OTHER REQUIREMENTS?

See the section titled Deemed Exhaustion.

EXTERNAL REVIEW (45 CFR § 147.136)

If a member has exhausted the internal appeal process for an adverse determination based on medical necessity and is still not satisfied with the decision, the member is guaranteed the right to an external review (for non-grandfathered, ACA-protected plans) by an independent, third party. This right is not offered for an administrative appeal.

The review will be conducted by an Independent Review Organization (IRO) and the

decision is binding on the insurer. The decision is not binding on the patient, who still has the right to proceed in court or arbitration when they lose at the external review phase, though many lawyers may find it more difficult because a supposed impartial "expert" has already denied the request.

There are two ways for a member to be eligible for external review:

- By completing all required internal appeal levels; or
- If the insurer does not meet the requirements of the internal appeal process (See section titled Deemed Exhaustion).

The external review process:

- A member or authorized representative must request an external review.
    - A member has 4 months to request an external review after the insurer responds to the final internal appeal level. (Reminder: For fully-insured plans, some state laws allow for longer timeframes)
    - The member may designate the provider as their authorized representative for the provider to have authority to file the external review.
- The required process and any specific forms should be outlined in the final appeal response letter. The member/provider should follow it completely and be sure to submit any requirements.
    - Some states charge a small processing fee (up to $25) for the external review, but the member can request a hardship waiver if the fee creates a financial difficulty.
    - In most states, the request must go to the insurance company. In a few states, however, the application for external review goes straight to the regulator or the designated IRO.
- The request for external review typically must be approved/denied within 6 days. If more information is needed for the insurer to make the decision, the insurer must request it from the member.
    - Tip: If the request for an external review is denied but should not be, contact the regulator.
- If approved, the insurer (or regulator) will choose the IRO at random or by rotation from a list of contracted IROs.

- For employer-sponsored self-funded plans, in most cases, the insurer reimburses the IRO for the external reviews, so members/providers should be on the outlook for any appearance of bias. All too often, IROs uphold the initial denial of care by the insurer. (Suspected bias in decisions can be reported to the Kennedy Forum. See the Who Can Help? section)

- The member will have 5-10 days to provide additional information to the IRO.
    - A member/provider can send the same information that was submitted in the internal appeal process or add additional information for process complaints if needed.
- IRO must review all information and provide a binding decision within 30-45 days.
    - The review organization generally has to defer to the insurer's medical necessity guidelines of the plan, even if the member/provider argues that those are incorrect. When an insurer uses medical necessity guidelines that do not align with the generally accepted standards of care, it is best to notify the insurer and the regulator of a potential MHPAEA violation, as those are the purview of the regulators and the courts.

Note: If the member plans to take legal action against the insurance company, they should consider consulting a lawyer before requesting an external appeal. If the IRO sides with the insurer and upholds the initial denial of care, it can hurt the case when filing a court action.

DEEMED EXHAUSTION

If a plan does not meet all of the requirements related to internal appeals listed above (e.g., does not meet the federal and state-mandated timeframes, does not provide sufficient information in the appeal response, etc.), it is **deemed** that the internal review process has been **exhausted** and the member may request an external review instead of another round of internal review. The **Deemed Exhaustion** provision can help a member/provider have their case reviewed more quickly by an external, independent third party.

Proving deemed exhaustion is often easiest for clear-cut process violations, such as a missed timeframe, but does apply to all requirements of the law. The plan may claim that the infraction was de minimis, for good cause, or beyond their control. If so, the member/provider can request a written explanation, and the insurer must respond within 10 days.

If a request for an external appeal is denied when internal levels remain, a member can still submit the next level of internal appeal. If an insurer refuses to allow an external review due to exhaustion when they should, the appropriate regulator should be notified.

REGULATOR COMPLAINTS

As mentioned throughout this guide, when insurers are violating the law, or even just not playing by their own rules, a member/provider can submit a complaint to a regulator and request assistance. See the Regulators section in Part I for more information about when and how a regulator can help. If you have questions about who to contact at the agency or about the complaint process, call the regulatory agency that you think is overseeing the insurance policy. Someone will point you in the right direction!

To file a complaint with a regulator, a provider should:

- Tie the complaint to one specific patient and insurance plan.
    - To complain about a pattern of behavior, a provider should choose one patient/plan (i.e., Patient A) as the example but then mention the broader pattern in the complaint letter. The letter should not contain the PHI for the other patients (Patient B, C, etc.) in that specific letter since it may be shared with Patient A, but redacted information can be included. If the regulator is interested in investigating a potential broader pattern of abuse, they will contact the provider to gather information.
- Identify the correct regulator based on the type of plan.
    - Determine the type of plan (self-funded or fully-insured) and for fully-insured plans, the state of the contract.
    - Regulators:
        - Fully-insured – State Department of Insurance (may have a similar name such as Bureau of Insurance, Insurance Administration, etc.)
        - Self-funded plans – the U.S. Department of Labor's Employee Benefits Security Administration (EBSA)
            - EBSA has 13 regional offices and 3 districts offices. A submitted complaint will be routed to the appropriate office. Phone

numbers and addresses are listed on the EBSA website.

- For others, see section titled Types of Healthcare Coverage.

- Check the regulatory agency's website for details on the process for filing a complaint.
    - There is often a "File A Complaint" link on the home page or in the menu bar.
    - For self-funded plans, EBSA has a complaint form available.
- Determine who may file the complaint. Most complaints must start with the member, but the member may be able to complete and sign a form to make the provider their authorized representative.
- Determine if the member has sufficiently attempted to resolve the issue directly with the plan.
    - Regulators usually require members/providers to exhaust the insurance company's internal complaint or appeal options prior to filing a complaint with them. The complaint process with the regulator typically involves the regulator reaching out to the insurance company to ask for a response to the complaint that was filed. The regulator does not want to disrupt an internal process that is already underway.
- Submit the complaint.
    - Most regulators have web forms that ask for specific information and then provide an area for a written narrative and/or a way to upload additional documents. Most will also allow a member/provider to send a letter with attachments.
    - The letter/narrative should:
        - Explain why the regulator's assistance is needed.
        - Include a timeline and any records of the communications to the regulator to show that the member/provider attempted to use the internal process but that it failed.
            - Include all earlier appeals and attachments.
        - Identify the ways in which the insurer is believed to have violated the law.

When filing a complaint with a regulator or otherwise communicating with them, be persistent in terms of follow-up. Many regulatory agencies are often short-staffed, so it is important to follow-up with them to ensure your issue is being addressed.

WHO CAN HELP?

Challenging a large insurer is daunting, but there are professionals and agencies that can help.

REGULATORY AGENCIES

See Regulators section earlier in the guide. One good resource to find contact information for regulators is on this Resources page of the Parity Registry and on the website of the National Association of Insurance Commissioners.

HR DEPARTMENTS (FOR SELF-FUNDED PLANS)

For self-funded plans, as is discussed earlier in this guide, the employer is the plan sponsor and has the fiduciary responsibility for the plan, even when they contract with a TPA to administer it. Therefore, when an employee is having difficulty accessing the benefits in a plan, the employee may want to contact the human resources department to explain the situation and see if/how they can help. Understandably, some employees will be nervous to share the situation with their HR department, so this step is not required. While it is illegal for an employer to discriminate against an employee based on the health status of a family member, each employee must assess their personal career situation and determine whether they want to involve their employer.

If an employer plan does not include an ABA benefit, then the employee should be directed to the Self-Funded Employer Toolkit on the Autism Speaks website. The toolkit provides resources for an employee to approach their employer about adding a benefit.

If the plan does have a benefit, but the employee is having difficulty using it, and the employee decides to involve the HR department, they may want to start with an emotional appeal (e.g., "You, [the employer], wanted us to have this benefit but the TPA is making it difficult for me to help my child."). Quite often, problems with an ABA benefit are likely a MHPAEA violation and the employer can be held

responsible. If so, the employee can let the HR department know of their concern (e.g., "I'm concerned "the TPA" may be violating MHPAEA by (violation example/s). If I understand correctly, our company may be held liable for that violation. I wouldn't want that to happen and I'm not sure (the TPA) has discussed it with you.").

CONSUMER ADVOCATES / ADVOCACY ORGANIZATIONS

Consumer advocates are professionals who provide information or specialize in helping consumers submit appeals and complaints. Some may only offer advice, and others may provide direct assistance with following up on claims, submitting appeals, and requesting external review. Some may charge fees, while others may have grants from government agencies or raise funds through donations to provide consumer assistance.

In some areas, a state/local legal aid office, the state's protection and advocacy agency (each state has one), or another advocacy group may provide limited assistance to low-income families or people with disabilities. Some adverse determination letters provide contact information for helpful agencies. Some employers offer their employees the help of an advocacy organization in appealing denials, but the amount and type of help varies by employer. Below are some organizations that may be able to help.

AUTISM DESERVES EQUAL COVERAGE FOUNDATION

Autism Deserves Equal Coverage Foundation envisions a world where individuals with autism spectrum and mental health disorders can, without a struggle and regardless of race, disability, or income status, obtain the health care services they need to maximize their potential and become happy, contributing members of their community. To that end, their mission is to help all individuals with autism spectrum and mental health conditions, their parents, families, healthcare providers, and other organizations that serve this deserving population, secure insurance coverage for medically necessary interventions across the lifespan. ADEC is a policy expert in the field, documents and researches rights and protections and barriers to access, and develops and executes strategies to overcome those barriers, resulting in an appeals success rate of approximately 95%, so its constituents can easily secure standard-of-care treatment and support without undergoing unnecessary steps or providing excessive documentation.

AUTISM SPEAKS

Autism Speaks envisions a world where all people with autism can reach their full potential. Autism Speaks is dedicated to promoting solutions, across the spectrum and throughout the life span, for the needs of individuals with autism and their families. Advocacy related to the health needs of individuals with autism is central to its work and it has led the insurance reform movement for over a decade to ensure that individuals with autism have access to the care and interventions they need. The Autism Speaks website has dedicated information about insurance issues and the Autism Response Team is available for questions from the autism community.

THE COUNCIL OF AUTISM SERVICE PROVIDERS (CASP)

The Council of Autism Service Providers supports its members by cultivating, sharing, and advocating for provider best practices in autism services. CASP is a non-profit association of for-profit and not-for-profit agencies serving individuals with ASD. Its member agencies care for more than 50,000 children and adults with autism across the U.S. and have collective revenues approaching 1 billion dollars. CASP represents the autism provider community to the nation at large including government, payers, and the general public. CASP serves as a force for change, providing information and education and promoting standards that enhance quality.

THE KENNEDY FORUM

The Kennedy Forum is a non-profit organization that seeks to transform the way mental health and substance use disorders are treated in our health care system. It is committed to the full implementation of MHPAEA and work to hold insurance companies accountable for complying with the law. The Kennedy Forum sponsors a website, called ParityTrack, which monitors and summarizes key state legislative, regulatory, and enforcement actions related to MHPAEA. There are many useful resources available to the public. In addition, they sponsor the Parity Registry which allows consumers and providers to file parity-related complaints and also offers state-specific resources.

Additionally, the Kennedy Forum published a Health Insurance Appeals Guide for help with any mental health-related claims. They also assisted with the publication of the CASP's Health Insurance Appeals Guide. One of the key participants in this Appeals Playbook project also led the Kennedy project.

THE MENTAL HEALTH AND AUTISM INSURANCE PROJECT

The Mental Health and Autism Insurance Project is a non-profit dedicated to helping families access insurance benefits for autism and other mental health conditions. The site provides a wealth of educational information and resources for families. The organization will also provide free advice to consumers (on an initial consultation) who want to file on their own. They will also file appeals and manage the regulatory process on a sliding scale fee for families. They also provide consultation to and will work with providers in certain situations.

THE NATIONAL AUTISM LAW CENTER

The mission of the National Autism Law Center (NALC) is to enforce and expand the legal rights of individuals on the autism spectrum and to serve as a resource for such individuals and their families, as well as to the service providers and attorneys who support them.

STATE SPECIFIC ADVOCACY ORGANIZATIONS

Throughout the country, there are several state-specific advocacy organizations that were founded by individuals who were integral to the movement for autism insurance reform. While their services mainly support families in their state, they have resources on their website that are valuable for anyone looking for information, and some do support families in other states. Here are some examples:

- Washington Autism Alliance
- The Autism Insurance Resource Center, based in Massachusetts.
- The ARC of Indiana Insurance Advocacy Resource Center
- Ohio Autism Insurance Coalition

LAWYERS

Sometimes, members and providers may decide to contact an attorney for legal help. If the member/provider has not received a favorable response through the internal appeal process nor received an adequate response or level of support from the plan's regulator, then the next best option may be to contact a lawyer for help. There are several lawyers with specific experience assisting with autism/ABA claims. Contact CASP for suggestions on how to find a lawyer in this field.

Although litigation can force the health plan to pay for medically-necessary ABA treatment or address other insurance coverage complaints, court proceedings typically are time intensive (sometimes several years) and resources to resolve. The good news is there is a growing body of court decisions on parity-related claims, which in turn puts pressure on any alleged violators to settle their claims.

For a lawyer or an advocate to best assist members/providers, it is critical that the members/providers correctly follow all steps listed in this guide such as meeting the timelines, receiving all notifications in writing, keeping track of all correspondences, etc.

When is it optimal to consult an attorney? Probably the ideal situation involves having multiple clients in a similar situation, going up against the same organization, denied for the same or similar reasons. Most lawyers prefer that the patients have not gone to external review and lost, as it makes it harder (but not impossible!!) for them to win because there is an alleged "independent" expert who says that the treatment is not medically necessary. If a patient is considering legal action at all, it is best to consult with an attorney BEFORE going to an external review.

When medical necessity is not in dispute, such as when there is an exclusion for ABA benefits, and the employer or regulator is not willing to challenge the health plan, litigation may be the best way to get needed services. See Doe v. United Health Care as an example of a successful case where UHC was required to provide ABA services even though the plan sponsor had elected to exclude coverage.

When the plan has violated the law, or the legal rights of patients or providers, and the regulator has not been able to help, it may be advisable to consult an attorney. Many attorneys will review cases at no cost and advise whether or not they think the case is worth pursuing. Some lawyers will work on contingency, but there needs to be a certain amount of money on the line to make it worth their while to pursue. Others will bill by the hour and may be able to recoup attorney fees from the defendant if the case is successful. There are many moving parts, and no two cases are the same.

Litigation is no quick fix. It often will likely take several years to get a resolution, and health plans can make lots of work for plaintiff attorneys and drive up the costs. Choose your battles carefully.

When the plan is clearly violating the law, sometimes issues can be readily resolved with a strong demand letter.

PART III: TIPS AND TOOLS

ADVERSE DETERMINATION TRACKING DOCUMENT

THIS DOCUMENT CAN BE USED to track the steps of the Appeal process. For any interactions with an outside party (insurer, external review organization, regulator, etc.), track as much information as possible – the date, who was involved, what was said, reference numbers, etc. If you are managing multiple appeals, it is also useful to have a spreadsheet to track the major steps in the process, but a word document will allow you to capture more detail about each interaction. These details may be important for future complaints.

Basic info

- Patient name / ID:
- Treating clinician:
- Insurance plan:
- Plan type (self-funded or fully-funded; if fully-funded, state of contract):
- Regulator:

Authorization / Adverse Determination info:

- Date authorization request submitted:
- Treatment requested (hours, locations, etc.):
- If relevant, information about review call (date, reviewer, discussion notes):
- Outcome of authorization request:
- Date of adverse determination notification:
- Appeal process per the adverse determination letter:

- Family notified, SPD and appeal documents requested (member appeal form, authorized representative form, etc.):
- SPD and family documents returned (date):
- SPD reviewed, esp. appeal process (date and notes):

First level Appeal

- Additional documentation requested from insurer (medical necessity guidelines, criteria, case specific documents) (date and notes):
- Additional documentation received from insurer (date and notes):
- First level appeal packet submitted (date):
    - MHPAEA disclosure letter included (yes/no):
    - Continued coverage requested (yes/no):
- First level appeal receipt by plan confirmed (date and reference number):
- First level appeal response received, including efforts needed to receive written copy (date):
    - First level appeal outcome and notes:
    - First level appeal – MHPAEA form response received? (yes/no):
        - If not received and past 30 days, or information insufficient, information submitted to Kennedy Forum? (date):
    - First level appeal – Continued coverage granted (yes/no):
- Deemed exhaustion criteria met? (yes/no):

Second level appeal (if required)

- Additional documentation requested from insurer (medical necessity guidelines, criteria, case specific documents) (date and notes):
- Additional documentation received from insurer (date and notes):
- Second level appeal packet submitted (date):

- Second level appeal receipt by plan confirmed (date and reference number):
- Second level appeal response received, plus any efforts required to get it (date):
- Second level appeal outcome and notes:
    - MHPAEA form response received, if not previously? (yes/no):
        - If not or information insufficient, information submitted to Kennedy Forum? (date):
    - Second level appeal – Continued coverage granted (yes/no):

External appeal

- Discussion on whether to consult an attorney prior to initiating external appeal (yes/no):
- Process for requesting external appeal (notes):
- Request for external appeal made (date):
- External appeal granted (yes/no and date):
- IRO assigned:
- External appeal response received (date):
- External appeal outcome (notes):

Regulator complaint

- Regulator complaint submitted:
- Regulator complaint response received:

TIMELINES FOR ADVERSE DETERMINATIONS AND APPEALS

ERISA regulations establish timelines for activities related to adverse determinations and appeals. Timeframes are provided in the chart below for standard appeals. Deadlines for urgent appeals are shorter.

For state-regulated plans, state law may provide additional guidance. The timeline that is most advantageous to the member governs. If a plan is state-regulated, visit www.regquest.com and enter the information in the "state-level" column, then choose the more advantageous timeline. Providers can complete this chart for all states in which they operate.

Step	ERISA (Standard Timelines)	State-level
PRIOR AUTHORIZATION		
Insurer must respond to request for prior authorization	15 days from request	
Plan can ask for additional information needed to make a decision	5 days from request	
Time for provider to respond to request for additional information	45 days from request for information	
ADVERSE DETERMINATION		
Time member has to appeal an adverse determination	180 days	
Timeline for insurer to notify member of appeal decision	If one level, 30 days If two levels, 15 days each level	
EXTERNAL APPEAL		
Time member has to submit request for external appeal	4 months from date of appeal response	
Time for insurer to grant/deny request	6 days from request	
Time for member to provide additional information to IRO	10 days after request	
IRO decision	45 days	

SAMPLE REASONS FOR REGULATOR COMPLAINTS

As mentioned throughout the guide, there are rules and regulations that insurance companies must follow to ensure that members receive a "full and fair" review. See the section titled Regulators: When Can They Help? for an explanation of the role that regulators play. Below is a partial list of instances when a provider may want to notify the regulator and ask for assistance.

Insurer is not following the required process or even their process:

- Documents (adverse determination letters, appeal responses, etc.) not provided in writing.
- Missed response timelines.
- Does not offer or allow for external review for a medical necessity denial.
- Not granting continued coverage during the course of an appeal for concurrent authorization requests.
- Unqualified reviewers.
- "Not playing by their own rules" – e.g., not stating that a specific form is required for the appeal process and then refusing to review an appeal without that form.

Patterns of concern:

- Medical necessity criteria not applied consistently across clients – e.g., provider cannot predict outcome of authorization requests, clients with same profile approved differently.
- Making providers "jump through hoops" – i.e., treatment is frequently denied, but then overturned on appeal.

Potential MHPAEA violations:

- Imposing QTLs such as visit limits or dollar limits more restrictively on mental health than on physical health conditions.
- Imposing NQTLs more restrictively on mental health than on physical health conditions.

- I.e., imposing limits on location of services, type of testing, etc. that do not align with what experts in the field recommend for delivering the best outcomes; or generally using medical necessity criteria that do not align with generally accepted standards of care.

Violation of disclosure requirements:

- For parity compliance, failure to respond to a disclosure request within 30 days:
    - A general analysis conducted to ensure plans meet parity requirements.
    - The medical necessity criteria used to make coverage decisions.
- For a denial of coverage, failure to disclose the specific reasons a denial was made for a patient.

Violations of state autism laws (for state-regulated plans):

- E.g., Authorizing less than 25 hours of therapy for a 4-year-old in Maryland when law requires a minimum of 25 hours authorized.

SUBMITTING A MHPAEA DISCLOSURE REQUEST AND REPORTING NON-COMPLIANCE

When health plans deny treatment for mental health conditions based either on quantitative treatment limits (e.g., visit limits, cost share levels) or non-quantitative treatment limits (e.g., use of medical necessity guidelines that do not align with the generally accepted standards of care), they are very possibly violating the federal parity law (MHPAEA). The law is meant to protect patients with mental health conditions, such as ASD.

While only regulators can truly enforce the law, providers play a critical role in flagging violations and ensuring the law is being respected. Guidance is provided below on how to:

- Ask insurers to disclose how they are abiding by the law; and
- Report non-compliance both to the appropriate regulator and the Kennedy Forum's Parity Disclosure Project.

STEP 1: MAKING A DISCLOSURE REQUEST

Since ASD is a mental health condition, we recommend that a parity disclosure request be made with all/most appeals for ABA. A request can also be submitted alone, without an appeal. The Kennedy Forum has created sample letters that can also be used to make a request. The templates are available at the links below. When submitting an appeal on behalf of a patient, a provider would use the "Adverse Determination Model Letter – Authorized Representative" version.

- Adverse Determination Model Letter - Authorized Representative
- Adverse Determination Model Letter - Member
- Plan Disclosure Model Letter - Authorized Representative
- Plan Disclosure Model Letter - Member

Federal regulators have also created a Parity Disclosure Request Form to help providers make a request. The Kennedy Forum letters and the Federal Parity Disclosure Request Form serve the same purpose.

STEP 2: REPORTING NON-COMPLIANCE WITH A DISCLOSURE REQUEST

When an insurer does not respond to a disclosure request, providers should report them to:

- The plan's regulator
- The Kennedy Forum Parity Disclosure Project at www.surveymonkey.com/r/parityresponse
    - The Kennedy Forum with help from the Center for Health Law & Policy Innovation at Harvard Law School will be tracking and analyzing the survey results. The survey requests information such as:
        - Information about the person completing the form
        - The patient's plan type
        - Basic information about what information was requested
        - Whether a response was received within 30 days and was adequate
        - A redacted copy of the request

APPEAL LETTER EXAMPLE (FOR DENIED HOURS)

Date:
Member:
ID#:
DOB:
Case number
Plan Sponsor:

Provider:
Tax ID:

Re: [First/Second] Level Appeal of a Medical Necessity Denial

To Whom It May Concern:

We are writing this letter to appeal the adverse determination based on medical necessity of the request for authorization for ABA services for [CHILD]. We are acting as the Authorized Representative of the member, [POLICY HOLDER], and have attached the Authorized Representative Designation form to this letter (Attachment A). [If relevant:] The Member Complaint and Appeal form is also attached to this letter (Attachment B).

We requested [CHOOSE prior authorization/concurrent review and authorization] for [explain treatment request, e.g. XX hours of treatment in XX setting] on XX date. We were notified of the adverse determination of [DENIAL] in an Adverse Determination Letter dated mm/dd/yyyy (Attachment C).
[Explain denial: e.g., XX of YY requested hours of treatment (ZZ%) were denied.]

[CHILD] is a child age [Years/months] who was diagnosed with autism spectrum disorder (ASD), F84.0, by [DOCTOR] on [XXX]. Based on the results of an assessment which included [list components, titles of specific assessment tools used, etc.], an individualized treatment plan was developed. To effectively implement [CHILD's] [comprehensive/focused] treatment plan, a dosage of XX hours per week of direct 1:1 ABA therapy plus additional hours for BCBA supervision and caregiver training was prescribed by the treating [Licensed] Board Certified Behavior Analyst. [#HOURS] hours per week of ABA therapy with clinical oversight is medically necessary for [NAME] and aligns with the generally accepted standards of care in the field.

[PROVIDER] strongly disagrees with the adverse determination and believes that anything less than the medically-necessary prescribed dosage of treatment will likely seriously jeopardize [CHILDs] ability to gain maximum function, effectively imposing a barrier to him/her being able to meet his/her fullest potential. All of the requested hours are medically necessary and appropriate. Denials/delays in treatment will likely result in increased costs and greater dependence on more intensive services across the life span.

Clinical Presentation
In this section, describe the background/history of ASD symptoms and how those symptoms affect the patients daily functioning. Be specific about any challenging or unsafe behaviors (i.e., aggression, elopement, property destruction or self-injurious behaviors). If relevant, include a summary of interventions and treatment tried to date.

If you have the specific criteria on which the decision was made, explain specifically how the patient meets each one. The criteria should be available in the Medical Necessity Guidelines and in any case notes received from the insurer.

Generally Accepted Standards of Care for ABA
In this section, explain the generally accepted standards of care of ABA. Cite the CASP guidelines, the APBA/BACB clarifications document, ABA Coding Coalition Model language, related research, support from national professional societies, etc.

Regulatory Concerns and Disclosure Requests

- In this section, cite any legal or procedural violations by the plan. Sample language that can be inserted here for the major types of violations are found in the Common Problems section on this guide. Examples include: Insufficient explanation of the denial, the use of Medical necessity criteria that do not align with the generally accepted standards of care in the field, basic procedural violations.
- In this section, notify the plan of the submission of a mental health parity disclosure request. You can use language such as, "In order to better understand the limitations that [INSURER} is imposing on the treatment for ASD, a mental health diagnosis, we have attached a mental health and substance use disorder parity disclosure request for your review and response within 30 days (Attachment H)."
    - For a second level appeal, if the initial parity disclosure request has not received a response, you can use this sentence instead: "A parity disclosure request was made with the first level appeal on [DATE] and a response was expected within 30 days. It has now been XX days and we have not yet received a response."
- In this section, you can also cite the fact that you are aware that the plan is accredited by [list accreditation agency], and that their actions/decision may be a violation of standards of that agency.

Continued Coverage
[Include this if the plan is trying to reduce hours from the last authorization period.]
Our patient began treatment on [start date] and is currently undergoing an on-going course of treatment. Under the continued coverage regulations of ERISA (45 CFR § 147.136), the patient is entitled to maintain the current level of care during the course of the appeal. We respectfully request that [Plan name] issue an authorization that maintains the member's current level of care at [XX level or YY hours/week] until the appeal process has concluded.

Conclusion:
Briefly summarize and state why ABA is medically necessary and restate what you are requesting.

If you need more information, please contact us at [Name and contact information].

Sincerely,
XXXXX

Attachments:
A – Authorized Representative Form

B – Member Appeal and Complaint Form

C – Adverse Determination Letter

D – Treatment plan

E, F, G, etc – Relevant documents to support the generally accepted standards of care (such as the CASP Guidelines)

H – Mental Health and Substance Use Disorder Parity Disclosure Request

REGULATOR COMPLAINT SAMPLE LETTER

To Whom it May Concern,

I am writing on behalf of PROVIDER and our patients who are members of INSURER. PROVIDER is a provider of Applied Behavior Analysis (ABA) for children diagnosed with autism spectrum disorder (ASD), a mental health disorder. Intensive ABA is well-supported as the generally accepted standard of care of children with ASD.

I am writing to document our experience with INSURER which has not dealt fairly with us or their members during our requests for authorization of medically necessary services. Please consider this letter a formal complaint against INSURER for denying our patients full and fair reviews, and in so doing, potentially inflicting harm upon them. PROVIDER has followed all of INSURER's processes yet has been repeatedly blocked from being informed and effective advocates for our patients. A number of issues that we have experienced are [CHOOSE ALL THAT APPLY AND INCLUDE OTHERS AS NEEDED. SEE "SAMPLE REASONS FOR REGULATOR COMPLAINTS".]:

INSURER using medical necessity guidelines that do not align with generally accepted standard of care in the industry and which contradict the clinical research in the field. This is both a violation of their fiduciary responsibility under ERISA, and an overly restrictive application of a NQTL to a mental health condition which is a potential MHPAEA violation.

Insufficient disclosure of the clinical rationale for denial of treatment requests, and adverse determination letters that do not include clinical justification specific to each member's individual treatment.

Lack of response to a MHPAEA disclosure request. [PROVIDE DETAIL ON DATE OF SUBMISSION AND INCLUDE A COPY OF THE FORM/LETTER SUBMITTED AS AN ATTACHMENT.]

Violations of UM regulations such as refusal to provide written denial letters and missed deadlines for appeal responses.

****

Each complaint should then be explained:
What happened, what did you try to do to try and resolve it, how did the insurer respond, and why was the response insufficient?

****

We request REGULATORS assistance in helping our patients access the medically necessary treatment they deserve and holding INSURERS accountable for abiding by federal (if applicable: and state) laws.

I can be contacted for questions at XXXXXX.

Sincerely, XXXXX

COMMON PROBLEMS

In this section, we examine common barriers the ABA community faces and provide suggestions on how providers can handle them. We are not attorneys offering legal advice, but do suggest possible violations of legal protections, as well as sample language to include in appeal letters. Providers should modify language as needed.

COMMON PROBLEM: INSUFFICIENT EXPLANATION (I.E., LACK OF DISCLOSURE)

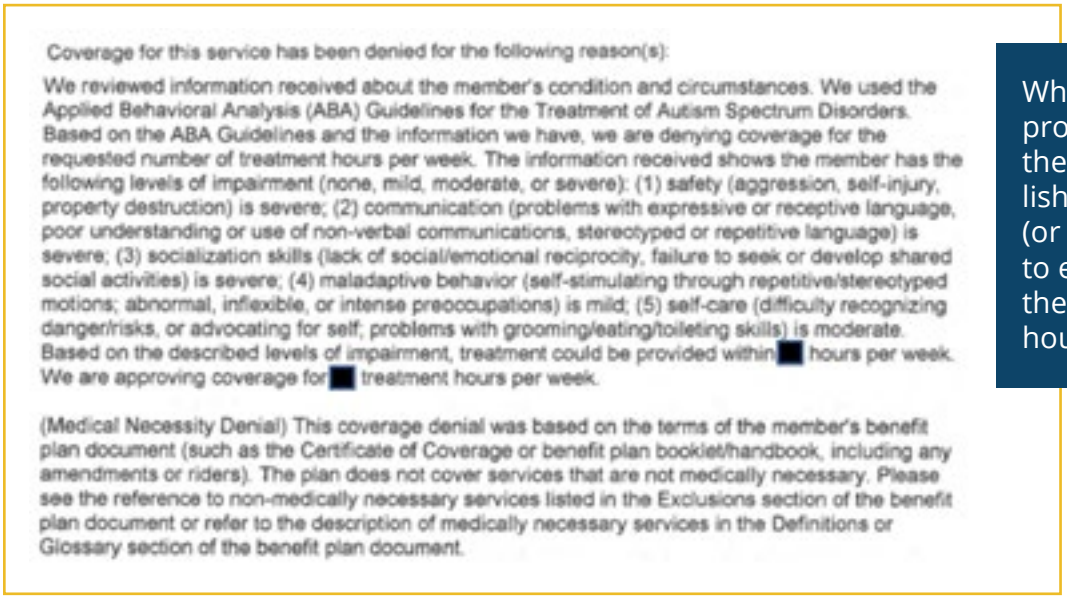
DESCRIPTION

When an insurer denies or partially denies an ABA authorization request based on medical necessity, it must provide a rationale for the decision. In the ABA community, providers often complain of a receiving a denial or partial denial without a clear explanation. This situation commonly manifests as an insurance company approving most of the treatment, but not the last 5-10 hours, claiming that ABA is medically necessary but not the full treatment dose prescribed by the treating clinician.

ERISA requires that adverse determination letters based on medical necessity or experimental treatment include "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation must be provided free of charge upon request." In addition, for medical necessity appeals, ERISA requires that the plan provide "documents, evidence, records, and other information related to the claim."

Similarly, MHPAEA requires that plans disclose the criteria used for medical necessity determinations and the reason denials are made.

Example #1: A denial letter without scientific or clinical judgment



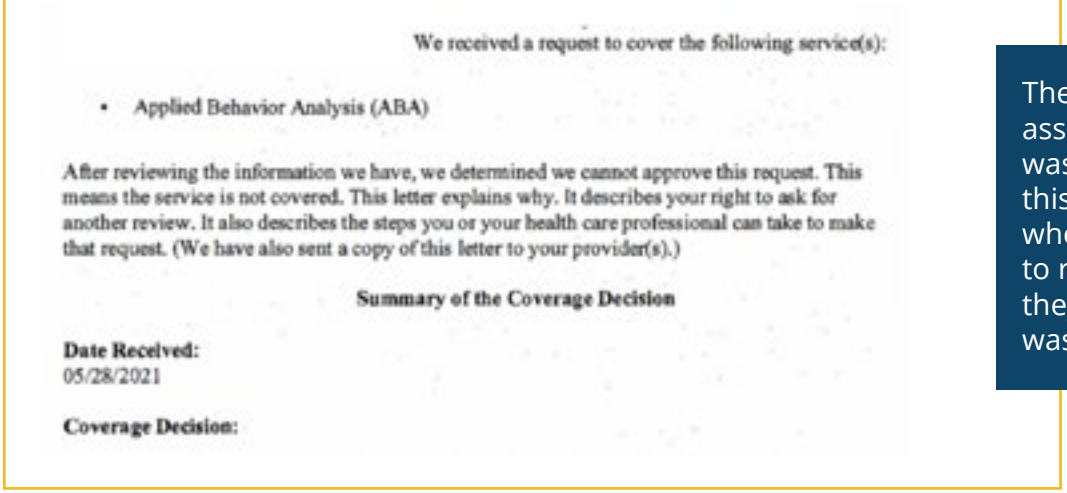
Coverage for this service has been denied for the following reason(s):

We reviewed information received about the member's condition and circumstances. We used the Applied Behavioral Analysis (ABA) Guidelines for the Treatment of Autism Spectrum Disorders. Based on the ABA Guidelines and the information we have, we are denying coverage for the requested number of treatment hours per week. The information received shows the member has the following levels of impairment (none, mild, moderate, or severe): (1) safety (aggression, self-injury, property destruction) is severe; (2) communication (problems with expressive or receptive language, poor understanding or use of non-verbal communications, stereotyped or repetitive language) is severe; (3) socialization skills (lack of social/emotional reciprocity, failure to seek or develop shared social activities) is severe; (4) maladaptive behavior (self-stimulating through repetitive/stereotyped motions; abnormal, inflexible, or intense preoccupations) is mild; (5) self-care (difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills) is moderate. Based on the described levels of impairment, treatment could be provided within [redacted] hours per week. We are approving coverage for [redacted] treatment hours per week.

(Medical Necessity Denial) This coverage denial was based on the terms of the member's benefit plan document (such as the Certificate of Coverage or benefit plan booklet/handbook, including any amendments or riders). The plan does not cover services that are not medically necessary. Please see the reference to non-medically necessary services listed in the Exclusions section of the benefit plan document or refer to the description of medically necessary services in the Definitions or Glossary section of the benefit plan document.

While the letter provides "ratings", there is no published research (or research cited) to explain how the ratings tie to hours denied.

Example #2: A letter with no explanation at all



We received a request to cover the following service(s):

- Applied Behavior Analysis (ABA)

After reviewing the information we have, we determined we cannot approve this request. This means the service is not covered. This letter explains why. It describes your right to ask for another review. It also describes the steps you or your health care professional can take to make that request. (We have also sent a copy of this letter to your provider(s).)

Summary of the Coverage Decision

Date Received:
05/28/2021

Coverage Decision:

The provider assumed a page was missing from this letter, but when they called to research it, they were told it was not!

STEPS TO TAKE

Follow the checklist for appealing an adverse determination

- Document all efforts made to access documents or explanations of the decision made.

Among other required items in Elements of an Appeal Packet, include:

- Sample language provided below, modified as necessary to meet the specific needs of your patient and situation
- A MHPAEA disclosure request letter

After attempting to determine the "why" of the decision, submit a complaint to the regulator that also uses the language provided below.

SAMPLE LANGUAGE

Under ERISA, in the case of an adverse determination based on medical necessity, the notification letter must include "an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation must be provided free of charge upon request." [Note: ERISA cannot be cited for individual policies. Only use the MHPAEA paragraph below in that case.]

The Mental Health Parity and Addiction Equity Act of 2008 (federal parity law) requires that plans provide the reason for any denial and "reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits… This includes documents with information on Medical Necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan."

Since the adverse determination Letter did not include such information but notified us that "XXX was available by calling YYY," we contacted the number provided on mm/dd/yyyy and requested information about how the decision was made.

[Insert here what was wrong with the response. For example: nothing was provided, the document provided simply re-stated the "not medically necessary" claim with no further detail to understand the "why," the documentation/rationale provided did not specifically apply the scientific literature to the patient's specific situation, etc.]

Due to the lack of specificity to our patient, we would argue that PLAN has not met the disclosure requirements of the regulations listed above. As a provider, while we can advocate for the medical treatment we believe our patient needs and deserves, we do not have sufficient information from [Insurer] to understand or refute why the reviewer disagrees with the treating provider's clinical judgment about the patient's needs and is therefore not authorizing a treatment plan that aligns with the generally accepted standards of care in our industry. We believe that this is a breach of [Insurer]'s fiduciary duties and impedes our patient's ability to access a full and fair appeal.

As a result of the potential MHPAEA violation, we are attaching a request for a mental health parity comparability analysis and expect a response within 30 days.

To further understand your process, we request the credentials and experience of the health care professional who was consulted in the initial review, the same for the professional who will conduct this appeal review, and disclosure of their relationship to each other.

COMMON PROBLEM: MEDICAL NECESSITY CRITERIA DO NOT ALIGN WITH GENERALLY ACCEPTED STANDARDS OF CARE

DESCRIPTION

ABA providers (like all health providers) must develop treatment plans that align with the generally accepted standards of care in the field. Unfortunately, it is not uncommon for an ABA provider to develop such a plan, but then have an insurance company fully or partially deny the treatment based on the insurer's internal medical necessity criteria or other standards that do NOT align with those same generally accepted standards. For example, the insurer's medical necessity criteria may deny treatment in certain settings, at certain dosages, or for a length of time that research shows would be most effective for the patient. Most denials fall into this category.

ERISA and UM regulations state that an insurer has a fiduciary responsibility to administer the plan on behalf of the participants, not to make money for themselves. By using medical necessity criteria that do not align with generally accepted standards of care, insurers breach that responsibility. In Wit v. United Behavioral Health Solutions, a federal court ruled in 2018 on this requirement. The core of the court's decision is that insurers must use medical necessity guidelines that align

with the relevant generally accepted standards of care.

In addition, using medical necessity criteria that do not align with generally accepted standards of care is likely a Federal parity violation. Parity regulations specifically list "medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness" as a nonquantitative treatment limit that must be applied consistently across medical/surgical and mental health/substance abuse benefits.

According to the federal parity law (MHPAEA) regulations about Non-Quantitative Treatment limits:

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

If we simplify this text related to medical necessity guidelines (i.e., medical management standards), it says: The insurer cannot apply medical necessity guidelines to mental health benefits unless they are comparable to the medical necessity guidelines on the medical/surgical benefits in the same service category (e.g., out-patient).

In fact, the law provides a specific example of an "appropriate" NQTL related to medical management criteria. In this example, the medical necessity guidelines for both types of services were developed by professionals with equal levels of expertise in their field and are applied in a clinically appropriate way.

> **Example:** A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that is based on clinically appropriate standards of care for a condition.

If we assume that the medical necessity criteria for the treatment of medical/surgical conditions are based on generally accepted standards of care in their fields, then having standards for ABA that do not align with the generally accepted standards in our field and that would not be supported by the experts in our field could be a violation of MHPAEA.

STEPS TO TAKE

- Follow the checklist for appealing an adverse determination.
- Among other suggested items in Elements of an Appeal Packet, appeal letter should:
    - Pay particular attention to clearly explaining the generally accepted standards of care in the industry, how the proposed treatment (including number of hours) aligns with those standards, and how the insurer's decisions and/or medical necessity guidelines do not align with, or even contradicts, those standards.
    - Include sample language provided below (modify as needed) and attach a MHPAEA disclosure request letter.
- If the initial appeal is denied, submit a complaint to the regulator including sample language below and a broader discussion about why the insurer's medical necessity criteria do not align with the generally accepted standards of care in the industry.

SAMPLE LANGUAGE

The adverse determination under appeal for the treatment of autism spectrum disorder, a mental health disorder, is a result of [Plan] applying a "medical management standard limiting or excluding benefits based on medical necessity or medical appropriateness," thereby imposing a nonquantitative treatment limit on an outpatient benefit.

According to 29 CFR 2590.712(c)(4)(i) that implements the federal mental health parity law (29 CFR 2590.712(c)(4)):

> A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use

disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Since the medical necessity guidelines used in the decision do not align with the generally accepted standards of care in the field and would not be supported by experts in the field, [PLAN] is applying a "process" and using an "evidentiary standard" much more "stringently" than it does to comparable questions of medical necessity for medical/surgical conditions. As such, we are concerned about a potential violation of The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA/federal parity law).

In Wit v. United Behavioral Health Solutions, it was found a health plan is responsible for ensuring their guidelines align with the generally accepted standards of care in the field, or that they use guidelines that have been published by leading non-profit professional associations to determine the appropriate level of mental health care needed in a given situation. United was found to be remiss by using internally developed guidelines that did not align with generally accepted standards of care and therefore violating United's fiduciary responsibility to administer the plan on behalf of its members not its profits. The internally developed medical necessity guidelines being applied in this member's situation do not align with the generally accepted standards of care in the field of ABA and therefore are contrary to the court's guidance in Wit.

As a result of the potential MHPAEA violation, we are attaching a request for a mental health parity comparability analysis and expect a response within 30 days.

COMMON PROBLEM: THE INSURER IS VIOLATING UTILIZATION MANAGEMENT PROTECTIONS

DESCRIPTION

As this guide outlines, there are laws and regulations that insurers must "play by" when handling utilization management decisions. These laws are designed to protect individuals who are in need of medically necessary treatment. When insurers are not following those rules, providers should hold them accountable. These

protections are granted via state and federal utilization management laws.

One way that insurers inhibit a member's access to treatment is simply by not following the process.

Examples of "process violations" include:

- Not providing a denial letter in writing
- Not notifying the provider/member of missing information for an authorization request and providing an opportunity to submit it
- Not responding to authorization requests or appeals within the allotted timeframe
- Not notifying a member of their right to, nor granting, external review for denials based on Medical Necessity after the internal process has been exhausted

STEPS TO TAKE

- Track patterns of violations by the insurer
- Submit a complaint to the regulator

Sample Language for Regulator Complaint:

To Whom it May Concern:

I am writing on behalf of [organization] which provides Applied Behavior Analysis (ABA) treatment to children with autism spectrum disorder (ASD), a mental health diagnosis. I am writing to document our experience with [plan] which has not dealt fairly with us or its member during our requests for authorization of medically necessary services. [Include if relevant: I describe one example below but have observed this to be a pattern of behavior by [plan] and am happy to provide you with additional examples.]

Please consider this letter a formal complaint against [plan] and their practices related to the authorization of medically-necessary services for our patients. Their violations of the protections afforded under ERISA impedes our ability to access a full and fair review, and in so doing, potentially inflict harm upon our patient, a child who is impacted by ASD.

[List and explain each violation.]

These actions are a violation of the plan contract provisions and of ERISA regulations.

We look forward to your assistance.

Example of a specific violation -- Refusal to abide by ACA's continued coverage regulation:

"[Member] is undergoing a course of Applied Behavior Analysis (ABA) treatment for autism spectrum disorder. The initial treatment plan was estimated to last XX years, as is common for a patient presenting with [his/her] symptoms. The insurer requires we submit for concurrent review and re-authorization for the treatment every YY months. Based on the most recent review, the plan is attempting to reduce the treatment level despite our recommendation that the higher dose of treatment hours is medically necessary. Under the continued coverage regulations of ERISA (45 CFR § 147.136), we have requested that the plan maintain the higher level of treatment during the course of the appeal. In violation of ERISA, the insurer has denied [or not responded to] our request."

APPENDIX A: REFERENCE LINKS TO KEY LAWS

IMPORTANT LAWS AND REGULATIONS are referenced throughout this document. Links to the specific laws and regulations are provided below.

At the federal level, health care coverage oversight and rule-making falls to three agencies: the U.S. Department of Labor, largely for group coverage; the U.S. Department of Health and Human Services, typically products that also fall within the jurisdiction of state regulators; and the U.S. Treasury, because health care coverage has tax implications. The Federal regulations regarding health care coverage, therefore, can be found in three separate sections ("Titles") of the Code of Federal Regulations (CFR) corresponding to each Department. Through a memorandum of understanding, the three departments develop and jointly issue health care coverage regulations under parallel provisions, so the three sections share similar language and include cross-references to each other.

The following laws are referenced in this guide, and their corresponding regulatory citations can be found here:

	Title 29 – LABOR	Title 45 – Public Welfare (HHS)
Adverse Benefit Determination – Concurrent Care	29 CFR 2560.503-1(f)(2)(ii)	45 CFR § 147.136(a)(2)
Discrimination prohibited	29 CFR § 2590.702	45 CFR § 147.104(e)
ERISA claims procedure	29 CFR § 2560.503-1	
Group Health Insurance Market Requirements	29 CFR Part 2590	45 CFR Part 146
Health Insurance Issuer Standards under the ACA		45 CFR Part 156
Health Insurance Reform Requirements (Group & Individual Market		45 CFR Part 147
Internal Claims & Appeals, External Review, Deemed Exhaustion	29 CFR § 2590.715-2719	45 CFR § 147.136
MHPAEA	29 CFR § 2590.712	45 CFR § 146.136
Network Adequacy and Continued Coverage		45 CFR § 156.230

APPENDIX B: GLOSSARY

ACA: The Patient Protection and Affordable Care Act—sometimes known as ACA, PPACA, or "Obamacare"—is a comprehensive health care reform law enacted in March 2010. The Act established minimum health care standards that must be obeyed by all non-grandfathered health insurance plans, including the right to an external review for decisions involving medical judgment.

ADMINISTRATIVE APPEAL: An appeal concerning the administrative processes of a health insurer. Administrative appeals do not involve clinical judgment and are only eligible for external review in certain states. Individuals should check their state department of insurance's website or contact their regulator directly for more information.

ADVERSE (BENEFIT) DETERMINATION: Any action by a health plan that denies or limits payment for the requested behavioral or medical treatment. The term can be used to refer to a partial denial in addition to a complete denial. The health plan must inform the patient of the adverse benefit determination and generally does so through an Explanation of Benefits (EOB) or denial letter. Synonymous with a denial of care.

APPEAL: The legal right of an insured individual, provider, or an authorized representative to contest a health plan or third-party determination to deny or limit payment for requested behavioral health or medical treatment.

APPELLANT: The individual, authorized representative, or ordering provider that is appealing a denial of care or other legal issue.

APPEALING A CLAIM: The process of contesting a denied behavioral health or medical claim in order to secure payment for services. Individuals, providers, or authorized representatives may submit appeals verbally or in writing. Most health insurers have their own processes and timelines, which may be subject to state and federal regulations.

APPLIED BEHAVIOR ANALYSIS (ABA): The process of systematically applying techniques based upon the principles of human behavior to reduce challenging behaviors and improve socially significant behavior to a meaningful degree.

AUTHORIZED REPRESENTATIVE: The person an individual chooses to act on their behalf in insurance or legal matters, such as a family member, spouse or provider. Authorized representatives must be identified in writing, and some authorizations require notarization.

BEHAVIORAL HEALTH: A descriptive phrase that covers the full range of mental health and substance use disorder (MH/SUD) conditions.

BENEFIT CLASSIFICATION: One of the six categories of benefits identified by MHPAEA (i.e., in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency, and prescription drugs).

NOTE: For Medicaid coverage, four categories of benefits apply (i.e., inpatient, outpatient, emergency, and prescription drugs).

CLINICAL APPEAL: An appeal that involves a "clinical judgment." Examples of clinical appeals are appeals related to a health insurer's denial concerning medical necessity of care, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, whether or not a service is custodial in nature, or whether or not a service is experimental/investigational.

CONCURRENT REVIEW: Utilization management conducted during a patient's hospital stay or course of treatment including outpatient procedures and services. Sometimes called continued stay review.

DENIAL LETTER: A formal letter issued by a health plan that details the reasons why an adverse benefit determination (denial) was issued. Denial letters must include a detailed explanation of the health plan's adverse benefit determination, as well as a notification of a patient's right to appeal a denied claim.

EXPEDITED APPEAL: An appeal that is conducted in a short timeframe because the denial of care could put the life or health of the patient in serious danger. An expedited appeal can also be filed if continued care is being interrupted. Expedited appeals are generally responded to in less than 72 hours and sometimes must be accompanied by a statement from a medical professional about why the patient's life is in danger without the care and why the appeal review should be expedited.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA): A broad-reaching federal law that establishes the rights of health plan participants, requirements for the disclosure of health plan provisions, and funding and standards for the investment of pension plan assets. ERISA provides specific protections for individuals appealing claim denials and establishes requirements for how a plan must review and respond to a claimant's appeal.

NOTE: ERISA is not applicable to all health insurance plans—most self-funded and fully-insured health plans offered through an employer are governed by ERISA. Religious organizations and government employee plans are exempt from ERISA.

EXCLUSIONS: Specific conditions, services, treatments, or treatment settings for which a health insurance plan will not provide coverage.

EXTERNAL (INDEPENDENT) REVIEW: A review of a health insurer's adverse benefit determination by an independent third party that may or may not be contracted with the health insurer. External review is part of the clinical appeals process and is designed to offer an independent and objective review regarding a disputed claim. External review is generally only available for decisions involving clinical judgment, but some states allow external review of all denial types. Individuals should check their state department of insurance website or contact their regulator directly for additional information. External review typically occurs after all internal appeals have been exhausted. However, this outside review can occur simultaneously to the internal appeals process in cases where an appeal decision will affect the life of a patient. Depending on the state, external reviews may be called Independent Medical Reviews (IMRs).

FAIL FIRST: Refers to a medical management protocol used by some health plans that requires a patient to demonstrate that they failed at a lower-cost therapy or treatment before the plan will authorize payment for a higher-cost intervention. Fail-first is considered a non-quantitative treatment limitation (NQTL) and must be comparable to, and not applied more stringently to behavioral health benefits than to medical/surgical benefits.

NOTE: Fail-first protocols used to deny coverage for entire behavioral health benefit classifications have been found to violate the federal parity law, as they are not typically utilized for medical conditions, except in the prescription drug class of benefits.

FULLY-INSURED PLAN: An insurance plan where the financial responsibility for medical expenses of plan participants is assumed directly by a health insurer. Individual plans offered on the health care marketplace are fully-insured and some employer plans can be fully-insured, depending on the employer contract with the health insurer. Fully-insured plans are regulated by state insurance commissions. Fully-insured plans are also sometimes called fully-funded plans.

GRANDFATHERED PLANS: Health plans and other designated insurance arrangements that were in existence prior to March 23, 2010, and have continued as they were originally written. Grandfathered health plans are not required to comply with some of the requirements of the ACA, including the requirement for an external review.

GRIEVANCE OR GRIEVANCE PROCEDURE: A complaint filed by an insured person related to a payment issue or the contractual language of the benefit plan. Sometimes synonymous with an administrative or coverage appeal, depending on the language of the health plan and the applicable regulations. A grievance may also be filed when services have been denied or cut back and the plan has not provided a denial letter.

HEALTH INSURER: A licensed organization that provides health insurance coverage to groups or individuals. Synonymous with health plan.

INDEPENDENT REVIEW ORGANIZATION: A third-party organization that conducts external reviews. See external review definition.

INPATIENT: One of the benefit classifications outlined in MHPAEA. Inpatient is a term used to describe the highest level of care available, often rendered in a hospital setting.

INTERNAL APPEAL: An appeal review conducted by the health insurer. The first appeal in the appeals process is always an internal appeal, and some plans include two or more levels of internal appeal.

MEDICAID: A joint federal and state program that provides comprehensive hospital, medical, and behavioral health coverage to low-income individuals, qual-

ifying seniors, and disabled individuals. The Social Security Amendments of 1965 created Medicaid by adding Title XIX to the Social Security Act, 42 U.S.C. §§ 1396 et seq. Under Medicaid, the federal government provides matching funds to states to enable the local jurisdictions to provide coverage to individuals who meet certain eligibility requirements. The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to cover the costs of necessary medical and behavioral health services.

MEDICAL/SURGICAL BENEFITS (MED/SURG): For purposes of this Guide, the phrase refers to insurance coverage for medical and surgical (non-behavioral health) services.

MEDICALLY NECESSARY: Health care services that are clinically indicated for the diagnosis and/or treatment of a medical or behavioral health condition. The term medical necessity is used to label the guidelines (see below) that the insurer uses to evaluate whether the requested services are appropriate by their chosen standards. Medical Necessity Appeal: A clinical appeal filed when the health plan has denied payment or reimbursement for a level of care or service based on a lack of medical necessity.

MEDICAL NECESSITY GUIDELINES / CLINICAL CRITERIA: A utilization management tool established by health insurers to guide them in determining if care is medically necessary or otherwise covered for an insured individual. Clinical criteria describe the required symptoms for admission, continued care, and discharge from various levels of mental health and medical care according to the individual health insurers.

MEDICARE: A federal government program established under Title XVIII of the Social Security Act of 1965 to provide hospital expense and medical expense insurance to elderly and disabled persons. Medicare is divided into four parts. Part A covers hospital, skilled nursing, and hospice services. Part B covers outpatient services. Part C is an alternative called Managed Medicare, which allows patients to choose health plans with at least the same service coverage as Parts A and B and (most often) more than the benefits of Part D. Part D covers mostly self-administered prescription drugs.

MENTAL HEALTH AND SUBSTANCE USE DISORDERS (MH/SUDS): The phrase used in the Mental Health Parity and Addiction Equity Act (MHPAEA) and accompanying regulations, as well as certain state laws, to describe a range of behavioral health conditions.

MHPAEA: An acronym for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the landmark legislation that requires insurers to cover treatment for mental health and substance use disorders no more restrictively than treatment for illnesses of the body, such as diabetes and cancer. Synonymous with the federal parity law.

MEMBER: Also referred to as a plan participant; an individual who is enrolled in a health insurance plan. This can include the primary enrollee and their dependents.

NON-QUANTITATIVE TREATMENT LIMITATION (NQTL): Any non-numeric treatment limitation (e.g., non-financial limitation or other limitation on treatment that cannot be counted) imposed by a health plan that limits the scope or duration of treatment of MH/SUD or medical/surgical care.

OUT-OF-NETWORK: Physicians, hospitals, facilities, and other health care providers that are not contracted with the plan or insurer to provide health care services at discounted rates. Depending on an individual's plan, expenses incurred by services provided by out-of-network health care professionals may not be covered or may be only partially covered.

OUTPATIENT CARE: Treatment that is provided to a patient on a non-24-hour basis without an overnight stay in a hospital or other inpatient or residential facility.

PARITY: Often used as a short reference to ensuring health equity between MH/SUD insurance coverage and medical/surgical insurance coverage.

PREAUTHORIZATION: A decision by a health insurer or plan (before a patient receives a service) that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. The insured individual's plan may require preauthorization for certain services before they receive them, except in an emergency. Also referred to as prior authorization, prior approval, or precertification, depending on the health insurer.

QUANTITATIVE TREATMENT LIMITATION (QTL): Any treatment limitation expressed numerically, such as one based on frequency of treatment, number of visits, days of coverage, or days in a waiting period that limits MH/SUD or medical/surgical care.

SERVICES: Often include various treatments, therapies, drug coverage, and other benefits offered through a health insurer.

SELF-FUNDED PLAN: The type of plan typically used by larger companies or unions where the employer/union collects premiums from members and takes on the responsibility of paying employee and dependent medical claims. Such employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator (TPA), or they can be self-administered. The employer/union may also use a stop loss insurance carrier to handle large insurance claims. The self-insured employee health benefit plans are exempt from many state laws and are instead subject to federal (ERISA) law. Self-funded plans are sometimes called self-insured plans.

SUMMARY PLAN DESCRIPTION (SPD): A comprehensive description of the benefits provided by a health plan to its members. SPDs also include a description of how the plan operates, as well as a list of what services are and are not covered under the insurance policy. The SPD constitutes the insurance agreement between the insurer and insured and is the governing document of the plan. SPDs should be offered through the insurance company's website, an online exchange, or in-house through an employer's Human Resources department. The insurance broker, plan representative, or Human Resources personnel will know where to find it if the insured individual cannot locate it. Synonymous with benefit booklet, Certificate of Coverage (COC), and insurance policy. The Summary of Benefits and Coverage (SBC) is an abbreviated version of a health plan, typically presented in the form of a grid.

THIRD-PARTY ADMINISTRATOR (TPA): An individual or organization that is charged with managing the administrative affairs of a self-funded insurance plan. Depending on the delegated authority of the plan, the TPA may administer the claims, appeals, and/or complaints.

UTILIZATION MANAGEMENT: Sometimes referred to as utilization review, a process or program designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

Disclaimer: This list of terms is not intended to be exhaustive, and definitions will vary based on types of insurance products and applicable laws. These terms are useful in understanding the federal parity law and navigating the appeals process. However, the definitions or any other information contained in this Guide should not be relied upon as legal advice. Consumers, providers, and other stakeholders should consult directly with a regulator, attorney, or advocate for specific advice.